Vancouver Coastal Health Authority

North Shore/Coast Garibaldi, Vancouver & Richmond

STRATEGIES FOR A SUSTAINABLE HEALTH SYSTEM

(HEALTH SYSTEM REDESIGN PLAN)

2002/2003 TO 2004/2005

(April 23, 2002)

Vision

The draft Vision Statement of the Vancouver Coastal Health Authority (VCHA)n has been compiled from a variety of source documents developed by the health authorities that have amalgamated to form the Vancouver Coastal Health Authority. This draft Vision is consistent with the goals for the health care system enunciated by the Government of British Columbia.

High Quality, Patient Centered Care

Our Vision:

- The VCHA provides timely access to effective health care.
- The VCHA provides health care in a caring and respectful manner with sensitivity to the diversity of the population served.

A Sustainable and Affordable Public Health Care System

Our Vision:

- The VCHA is a leader in research, professional education and knowledge development and the integration of knowledge into best practices in our health care services.
- The VCHA supports a workforce that excels at providing needed health care.
- The VCHA evaluates and measures its performance and continuously improves the quality and cost-effectiveness of its services.

Improved Health and Wellness

Our Vision

- The VCHA services contribute to improved health status of the population especially groups experiencing poorer health status than the norm.
- The VCHA contributes to partnerships with other sectors such as municipal governments to address social factors that affect the health of the population.

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A Executive Summary

A1 Overview

Today marks the first step in our effort to reform and redesign health care so that patients are at the top of the list and get the care they need when they need it.

- Patients have made clear their dissatisfaction with how the system serves their needs. Health care providers have asked for a system with improved accountability. Today's initiatives are fundamental to building a sustainable health care system that meets patients' needs.
- There are five components in our approach to restoring confidence in health care. Each component is distinctive in its purpose, and together they constitute an innovative, effective, and long-overdue redesign of an ailing health care system. Moreover, the approaches we are using uphold the standards of affordable, reliable, and effective health care, and are the foundation of generating higher levels of patient care, support, and confidence.
- All of us who value our health care system — communities, patients, health care providers, and the public — have a role to play in making these new approaches work, and are included in our actions. In beginning the effort to redesign our health care system we will deliver these changes in a financially responsible way, working cooperatively with communities throughout the VCHA.
- The work ahead will continue to be challenging, but through this ongoing effort, we will deliver health services in a cost-effective and sensitive manner that recognizes the needs of patients and taxpayers. Today's initiatives, and those we will take in the future, put patients at the top of the list.
- In our approach, each dollar we put into the system does as much as it can for patients. We're providing patient service in a more cost-effective way, and we're responding to patients' interests and giving them the care they need. In launching our approach today, we are firmly on the course to achievement of long-term health care stability, a long-term increase in the quality of care, and a long-term increase in care standards.

Today marks the beginning of our fundamental redesign of health care to provide the right services, at the right place, delivered by the right people, at the right cost -- for patients who rely on the VCHA.

A2 Clinical Efficiencies Strategy

Putting patients at the top of the list in the health care system means finding better ways of doing things, and making better use of resources so that patients get the care they need. Clinical efficiencies in areas like home support, the operating room, and residential care, will produce lasting benefits to patients, and are a central feature of our health care redesign.

- One area where clinical efficiencies can be achieved is in the area of ***day surgery***. Our approach will see the VCHA make greater use of new surgical techniques and technologies that make surgery less invasive, and as a result reduce the need for lengthy

A Executive Summary (continued)

patient stays in hospital. This will mean faster recoveries for surgery patients, a quicker return to home and family, and earlier availability of hospital beds for other patients who need them.

- These same efficiency gains will be achieved in the area of ***home support***. Previously, home support agencies supplied home care services across the region, requiring home support workers to spend more time in their cars than with patients who needed their care. As well, the number of providers consumed significant administrative resources that should have gone to patient care. Our plan will see home support workers targeted to a smaller geographic area, meaning more service for patients. As well, we will work with fewer firms in order to reduce our administration costs and to secure the best patient value for our home support dollars.
- Our focus on clinical efficiencies will provide key benefits to people living with ***chronic conditions***. For instance, whenever a person with diabetes visits a community health centre for whatever reason, we'll ensure they're getting the tests and check-ups necessary to make early diagnosis of diabetes-related conditions. This action will enhance the quality of life of the patient, and make sure that serious complications are caught early or are prevented. This means that people with a chronic condition can reduce the potential for high-intensity, high-cost interactions with the health care system. Resources saved through this action are available for others who require care.
- Clinical efficiencies will also bring benefits in ***residential care***. Traditionally, when seniors experienced a decline in their physical and mental functioning, they moved to residential care — even if they didn't need the full range of supports of residential care. Our approach favours seniors getting the care they need, by ensuring that seniors have the supports they require in their homes and their community where they can maintain their independence. We will develop assisted living facilities where supports are available for seniors as needed, and independence is maintained.

Each of these clinical efficiencies — and others like them in our approach — represents a significant change in the delivery of health care. We're providing patient service in a more cost-effective way, and we're responding to patients' interests and providing the care they need.

A3 Operational Efficiencies Strategy

Each dollar we put into the system must do as much as it can for patients. It is essential that we deliver health services in a cost-effective and sensitive manner that recognizes the needs of patients and taxpayers. Our action in generating operational efficiencies in administrative service and infrastructure will ensure support and resources for front-line caregivers.

- The VCHA has taken the first step in generating operational efficiencies **by reducing executive-level positions by 25 percent, and reducing management staff by 14 percent**. Moreover, the new executive team is accountable for achievement of defined objectives and collective goals, an important component to the effort to put patients and their care at the top of the list.

A Executive Summary (continued)

- Another operational efficiency will be gained through use of alternative and shared service delivery, as in the example of the cleaning of non-patient areas such as administrative offices, research areas, and doctors' offices. By using the alternative service model, we will reduce the dollars spent on cleaning. Through effective use of shared services, we will further reduce spending on such non-patient operations by negotiating cost-effective contracts that cover multiple facilities. The resulting reduction in management time spent on non-patient service will yield additional savings. In all, VCHA action on alternative and shared service efficiencies will produce $40 million that will be used to protect patient services and care.
- Operational efficiencies will extend to such areas as absenteeism. Health care workers across Canada are absent an average of 11.8 days per year compared to 6.7 days for all other workers. A part of the difference can be attributed to inadequate information systems, inadequate workplace health strategies and attention and staff expectations that have developed over time. The overtime paid to other workers as a result of sick days is substantial. As an operational efficiency, the VCHA will assist the entire organization in reducing the cost of sick time and overtime, in order that our redesign of health care proceeds in a financially responsible way.
- We will also create operational efficiencies by redesigning the workplace. For example, several of our hospital units that have a combination of acutely ill and more stable patients are staffed by combinations of Registered Nurses and Licensed Practical Nurses (LPNs). The LPNs have been taking a training program to develop skills based on the latest educational standards. These LPNs will begin to have full responsibility for the more stable patients, doing assessments, planning care, and delivering care including giving medications. This will be more satisfying and rewarding for the staff, and more consistent and less fragmented for the patients.

Achieving gains in operational efficiencies is an important part of the work to redesign our health care system. We are continuing to review how we deliver health care in the VCHA, and are looking for new approaches, structures, and methods of health care service and delivery that are sustainable and affordable, cost-effective, and patient-centred.

A4 Service Alignment Strategy

To put patients at the top of the list, we must be deliberate and thoughtful about what we should be doing in health care and where we should be doing it in the VCHA. In realigning services we will ensure that health care facilities and activities are available, accessible, and focused on the patient

- In Vancouver, much of our **hospital infrastructure** was built in a different time, for different needs. In Vancouver alone, there are seven separate hospital sites, each with many overlapping services, in addition to those of the Provincial Health Services Authority. Not surprisingly, there are numerous beds not being used, while other areas are bursting at the seams. **Through consolidation**, which means dedicating certain services to certain facilities, we will provide patients with better service and care. For example, the Providence Legacy Project will pull together acute and rehabilitation services on to two sites from the existing four. By undertaking service consolidation, we free up resources for patients that might otherwise have been allocated to buildings.

A Executive Summary (continued)

- Over the years, Vancouver has become a centre for a great number of general and specialized hospital care services. During this same period, however, other parts of the province have grown, and yet remain dependent on the provision by Vancouver of these general and specialized hospital services. **Putting patients first means ensuring that patients in other health authorities have the general, if not all the specialized services, they require where they live.** VCHA will work with other authorities to develop regional services, which will provide a better care continuum for communities across BC.
- In some cases, we have the answers to service realignment, and are taking action. In other areas, we know there are problems, and need to determine the **best solutions**. Accordingly, we are initiating **studies in a number of areas to identify the best practices that will lead to long-term health quality gains**. In the case of operating rooms, this means looking across the region for techniques and instruments that contribute to shorter and less invasive surgeries, and faster recovery times. The results of these studies will help us consolidate general and specialized services in a way that enhances care and service to patients.

Affordable, reliable, and effective health care is the foundation for higher levels of patient care, support, and confidence. With our service realignment strategy, we are on course to long-term health care stability, a long-term increase in the quality of care, and a long-term increase in care standards.

A5 Revenue Generation Strategy

Effective budget management is essential to ensuring the sustainability of our health care system. While each dollar put into the system must do as much as it can for the patients, we must also ensure that every opportunity is taken to bring new money into the system. Securing revenue-generating opportunities that are sensitive to the needs of patients and taxpayers is an important part of our health care redesign. Where user fees will further enhance or supplement patient care, and are in keeping with the *Canada Health Act*, they will be considered as well.

- Revenue generation for the VCHA can come in many forms. The **$7 million** contribution anticipated over the next three years will come from business-to-business initiatives such as exclusivity-of-supply arrangements with a soft drink company, for example. Discretionary room amenities — items patients can purchase to make their hospitalization more comfortable — are also being explored. In addition, we will derive revenue from retail and space rental.
- User fees are being considered in some areas where their application is appropriate. For instance, after open-heart surgery, cardiac rehabilitation usually requires dietary monitoring, exercise, and lifestyle changes. In cases where discharged patients prefer to use hospital facilities and instructional staff, a user fee will apply.
- While the cost of particular health care services are generally not known by most Canadians, it remains that for many non-Canadians, such costs are known. This awareness, coupled with knowledge of Canada's medical expertise, has created a market among non-Canadians for our medical services. For the VCHA, additional revenue opportunities arise in providing non-primetime access to health services for

A Executive Summary (continued)

out-of-country residents who wish to purchase them from the VCHA. We are exploring the potential to access this revenue source in a manner that would not interfere with the provision of services to Canadians, but would in fact help fund them.

Revenue generation is a small but important component in our health care redesign. Its purpose is to insure additional financial support to our health care system, in order that it is sustainable and meets patients' needs.

A6 Health Promotion/Illness Prevention/Harm Reduction Strategy

The fifth strategy in our health care redesign is one that has marked our approach to health care since its earliest days. Health promotion, illness prevention, and harm reduction have always been a part of health care. The need for our redesign of the health care system makes these features more important and vital than ever before.

- **The need for the promotion, prevention, and reduction approach is most evident in our Aboriginal community.** At present, an adult male Aboriginal has a life expectancy 17 years below the average. Our aboriginal strategy saw us complete "Healing Ways," a Vancouver aboriginal health report. This distressing report revealed that the health status data for the aboriginal community is lower than average in all measures. Our approach will see us with aboriginal families to ensure they have the tools they need to raise healthy children. These and other approaches will reduce the aboriginal health challenges and preserve health funding for additional targeted purposes within the aboriginal community.
- British Columbia's **Downtown Eastside**, located in the VCHA, continues to lead the nation in every negative measure, including health. Our health care redesign will see us ensure that health dollars are better orchestrated and are targeted to the best use in the community. This means we will put more primary care into the community including more clinics offering methadone and more contact and referral centres.

  As well, we will be creating an evaluation strategy to ensure that our efforts in health promotion, illness prevention, and harm reduction play an effective role in reducing the Downtown Eastside interaction with the health care system in the short- and long-term.
- The critical years in a child's social and physical development are the first five years of life. If the right environment can be created, then a clear path can be established to better social, mental, and physical health in later years. For example, we will work with high-risk mothers and newborns through initiatives such as home visits and a telephone hot line program to provide the support they require. The benefit to the health care system is obvious.
- The promotion, prevention, and reduction effort extends to those people with multiple chronic diseases. A reality of our health care costs is that individuals with multiple chronic problems are heavy users of the health care system. Our health care redesign will allow us to identify individuals in the VCHA with multiple chronic problems. Once

A Executive Summary (continued)

identified, we will look for treatment patterns and examine available research in order to devise the best approach to treating these individuals and reducing their interactions with the health care system.

All of us who value our health care system — communities, patients, health care providers, and the public — have a role to play in health promotion, illness prevention, and harm reduction. The pressures that have necessitated this health care redesign will always be with us, but we can control their impact on the cost and availability of health care by being diligent in our attitudes towards lifestyle, behavior, and their impacts on our health.

A7 Background to Health System Redesign

A7 a) The Financial Impact of the Health System Redesign

It is our goal to fundamentally redesign and improve health services in the Vancouver Coastal Health Authority. At the same time, we have a budget challenge of $163 million over three years on an expenditure base of almost $2 billion per year. Corrective action is required to create a sustainable system into the future. If our health care system is to respond to patients' needs, we must make decisions that restore value-for-money and confidence in health care.

Our total reduction is less than 1.3 percent of our $1.9 billion cost base. In short, 98.7% of our services across the VCHA will be retained or improved over the course of our three-year redesign plan.

The VCHA created this health service redesign plan and corresponding budget management plan, attached in Appendix "B". There is a structural operating deficit projected at the end of 2001/02 of $54.7 million. An additional $174.0 million in additional cost pressures is expected over the next three years, and a $2.0 million contingency for B.C. Ambulance Services. That amounts to a total of $246.1 million, to which is added a one-time requirement of $15.4 million for the total costs of severance to be incurred.

The VCHA is expecting $85.7 million in new Ministry of Health funding, or about one-third of the total pressures. The budget management plan identifies a total of $162.6 million in budget management strategies over the next three years. This document explains the redesign strategies, which will yield system improvements as well as efficiencies that, will deal with over 84 percent of the challenge. It also explains $25.2 million in reductions, representing 15.5 percent of the budget management challenge, but only 1.3 percent of our total service and cost base.

A Executive Summary (continued)

A7 b) Geographic Area and Management

The Vancouver Coastal Health Authority (VCHA) encompasses the North Shore/Coast Garibaldi (NS/CG) Health Service Delivery Area (HSDA) that now includes the Central Coast and Bella Coola Valley areas, as well as the Vancouver and Richmond HSDAs. All direct services in the NS/CG and Richmond areas are operating entities led by Chief Operating Officers (COOs). The Vancouver HSDA is organized into three operating entities, Vancouver Acute (VHHSC) and Vancouver Community led by COOs and Providence Health Care (PHC), which is affiliated by virtue of the denominational agreement and is led by a CEO. The VCHA corporate functions were identified as another 'entity' for the planning process.

A7 c) Health System Redesign in Two Stages

To develop the health system redesign plan we have directed our attention to services within the Health Service Delivery Areas of North Shore/Coast Garibaldi, Vancouver and Richmond. This stage began with the restructuring of the senior executive team. Our new team brings together representation from all geographic and clinical areas of the Authority to encourage a commitment to integration, accountability and patient care. Every portfolio was designed to promote a systems approach to the integration of services throughout the Vancouver Coastal Health Authority. We looked closely at how we integrate acute and community services within each health service delivery area. As a result, our plan will avoid unnecessary use of the most costly parts of the system, and will provide appropriate and efficient service in each part of the system. Our plan is based on a broad consideration of continuity of care and services for each of the major geographic areas under our responsibility.

Effective immediately, as the second stage, the VCHA will embark on a set of region-wide system design initiatives. Project charters are being prepared over the next month for studies to further improve performance and to address the distribution and coordination of the following services:

- Surgical services, including an examination of Operating Room (OR) best practices.
- Emergency services.
- Provincial adult rehabilitation services. (To be proposed to the Leadership Council to examine the province-wide network of services.)
- Rural acute services.
- Residential care and assisted living.

These studies will be designed to enable the VCHA to improve on the levels of service, quality, and efficiency contained in this plan.

Through the work we have done in preparing the health service redesign plan and budget management plan we will create a patient-centred health care system that provides value for money in terms of the health of the people we serve and the quality of care and service they receive. The health system redesign will also ensure that the system is sustainable in terms of human resources, facilities and financial requirements.

A Executive Summary (continued)

The studies included in the second stage will enable the VCHA to improve levels of service, quality and efficiency. Except for the rural acute services review that is specific to the North Shore/Coast Garibaldi operating unit (including Bella Coola and the Central Coast), these projects will involve all entities within the VCHA including Providence Health Care. It should be noted that Providence Health Care (PHC) led the first phase of the emergency services review at the request of the region and that the Providence Legacy Plan presents both opportunities and requirements for the emergency, rehabilitation and residential care plans. The PHC summary document emphasizes their commitment to work with the VCHA in designing a transformed health system.

The document that follows is a summary of the major initiatives proposed for the Vancouver Coastal Health Authority. Most of the initiatives begin in 2002/2003 (Plan Year 1), with further steps in 2003-2005 (Plan Years 2 & 3). Information has been organized according to the sectors identified by the Ministry. Because our organizational and financial systems are not structured in that manner, the categories are not precise. In particular, the section identified as Support and Administration does not yet conform consistently to the new Ministry specifications.

The major initiatives as described have been developed to achieve the directives set out in the Performance Agreement and corresponding materials. This section also provides an overview of the principal considerations that guided the initiatives.

Note: Core services have been maintained in all clinical and support areas.

A8 Key Facts

- Vancouver Coastal Health Authority has a budget challenge of $163 million over three years on an expenditure base of almost $2 billion per year.
- The Vancouver Coastal Health Authority (VCHA) encompasses the North Shore/Coast Garibaldi (NS/CG) Health Service Delivery Area (HSDA) that now includes the Central Coast and Bella Coola Valley areas, as well as the Vancouver and Richmond HSDAs.
- Reductions are limited to $25 million or less than 1.3 percent of our $1.9 billion cost base.

B Acute Sector – Introduction

Rationalization of acute services has been underway in the VCHA for over a decade.

In the early 1990s, the Vancouver teaching hospitals began a collaborative planning process through the Council of University Teaching Hospitals. This culminated in a Joint Agreement between VHHSC and St. Paul's Hospital in 1994 agreeing to a set of service transfers creating the following Centres of Excellence:

St. Paul's Hospital: AIDS
Heart Centre (Cardiovascular Sciences)

VHHSC: Neurosciences
Trauma
Cancer (Surgical Oncology)

They also agreed to differentiate in 8 other program areas and to recognize a lead facility in 7 more.

In 1997, the Vancouver/Richmond Health Board completed a Review of Acute and Rehabilitative Services. It encouraged consolidation of facilities within VHHSC and Providence Health Care and directed Richmond Health Services to:

- Accommodate the growth in appropriate demand for the Richmond population in those services it offers.
- Consider transferring its low volume resource-intensive specialized services to Vancouver in order to improve critical mass and to enable growth in other services.

It was also decided that the V/RHB should support other regions in moving towards handling their regional growth in the need for the services they deliver.

The VCHA currently has the following sites in Vancouver:

Provincial/tertiary: VHHSC-VGH
VHHSC-UBCH
VHHSC-GF Strong (rehabilitation)
PHC-St. Paul's

Community: PHC-Mount Saint Joseph
PHC-St. Vincent's
PHC-Holy Family (rehabilitation)

The implementation of the VHHSC site configuration plans and the Providence Legacy Project will result in two adult acute/rehabilitation provincial/tertiary sites at VHHSC-VGH and PHC-St. Paul's, a provincial/tertiary psychiatry and ambulatory site at VHHSC-UBC and a community hospital at PHC-Mount Saint Joseph.

Richmond and Lion's Gate will continue to serve as regional centers for their areas (over 168,000 population each). Three community hospitals in Coast Garibaldi serve small but geographically separate populations. Two small community hospitals in Central Coast (RW Large) and Bella Coola serve very small populations in a geographic area that is both remote and widely dispersed.

The acute service system in Vancouver is already highly differentiated, and with this consolidation will be one of the most streamlined acute systems in a major metropolitan area in Canada. The remainder of the acute service system in the VCHA is generally sized in relation to the geography and population density of the various communities.

B Acute Sector - Introduction (continued)

The strategies for a sustainable system include particular attention to utilization management and productivity, stressing the provision of effective and appropriate admissions, procedures and days of stay for the appropriate regional and provincial population.

In the next stage, the VCHA will conduct projects specific to the surgical, emergency, rehabilitation and rural acute sectors. Their purpose will be to:

- Create the linkages for an effective regional, and as appropriate provincial acute/rehabilitation network.
- Balance the factors associated with clinical quality, geographic accessibility and academic mandate to determine any service realignments required.
- Ensure cost-effective and sustainable service delivery.

C Clinical Efficiencies Strategy – Acute Care

- Putting patients at the top of the list in the health care system means finding better ways of doing things, and making better use of resources so that patients get the care they need. Clinical efficiencies in acute areas like the operating room, and community service areas like home support and residential care, will produce lasting benefits to patients, and are a central feature of our health care redesign.

- One area where clinical efficiencies can be achieved is in the area of ***day surgery***. Our approach will see the VCHA make greater use of new surgical techniques and technologies that make surgery less invasive, and as a result reduce the need for lengthy patient stays in hospital. This will mean faster recoveries for surgery patients, a quicker return to home and family, and earlier availability of hospital beds for other patients who need them.

Utilization Management and Productivity

Performance improvements in the areas of utilization management and productivity are vital to our success and are a critical part of this plan in the acute sector.

- Utilization management.
- Productivity improvement.

The Health Service Redesign Plan incorporates improved resource utilization in the following ways.

- Identification and removal of 'may not require hospitalization' (MNRH) days.
- Transfer of acute surgical cases to same day care where appropriate.
- Identification and reduction of inappropriate days of care through application of the ISD-A criteria (Vancouver) and through benchmark comparisons (Richmond & North Shore/Coast Garibaldi).
- Identification and reduction of 'alternate level of care' (ALC) days.

The plan assumes improved productivity levels. For Vancouver Acute these are based on internal benchmarking/analysis and application of best year over year productivity rates (hours/per patient day; workload units/per hour worked, productive hour comparison etc).

D Service Alignment Strategy

- To put patients at the top of the list, we must be deliberate and thoughtful about what we should be doing in health care and where we should be doing it in the VCHA. In realigning services we will ensure that health care facilities and activities are available, accessible, and focused on the patient.

- In Vancouver, much of our **hospital infrastructure** was built in a different time, for different needs. In Vancouver alone, there are seven separate hospital sites, each with many overlapping services, in addition to those of the Provincial Health Services Authority. Not surprisingly, there are numerous beds not being used, while other areas are bursting at the seams. **Through consolidation**, which means dedicating certain services to certain facilities, we will provide patients with better service and care. For example, the Providence Legacy Project will pull together acute and rehabilitation services on to two sites from the existing four. By undertaking service consolidation, we free up resources for patients that might otherwise have been allocated to buildings.

It is vital to maximize the use of available resources for patient care. Hence, both VHHSC and Providence Health Care decided to examine the configuration of services and to conduct a high-level analysis of the advantages and disadvantages of various scenarios. Within the VCHA and more specifically within VHHSC and Providence Health Care, there is considerable acute care physical capacity not being used for that purpose. For many years, appropriate inpatient activity has been shifting to day care and outpatient service and lengths of stay have been shortening, resulting in fewer beds in use. At present, there are approximately 400 beds not staffed or in use between VHHSC, PHC and RHS. With continuing improvements in utilization management and increasing self-sufficiency of other regions of the province, these are not expected to be required in the future. Both VCHA and PHC have been concerned about the inefficiency associated with functioning on multiple sites.

D1 VCHA Site Configuration

Within VCHA's directly administered services, the Senior Executive Team has identified the following possible option.

- The potentially relocation of inpatient and day surgical acute care activity from UBC Hospital Koerner Pavilion to the VGH site. UBC Hospital remains a location for psychiatry and mental health services, ambulatory services, extended care services and activities associated with research functions (e.g. Brain Centre) with an increased role/level of academic activity.

There is sufficient capacity on the VGH site to accommodate the transfer of activity. With the completion of the Jim Pattison tower at VGH next year and the subsequent renovations to the Centennial Pavilion, there is an immediate opportunity to ensure suitable physical facilities for consolidation.

In addition, there have been discussions for a number of years about the value of maintaining the identity of the provincial rehabilitation services of the GF Strong Centre while also improving the proximity and linkage to related provincial acute services at VGH. There are expected to be clinical and academic synergies associated with relocating GF Strong to the VGH site, as well as some efficiencies.

The overall program and space requirements need to be established through a provincial review that considers the level of rehabilitation capacity that should continue to be centralized provincially and the level that should be available in individual regions. With expected consolidation of residential capacity in Vancouver, the Banfield Pavilion might be made available for conversion and expansion to enable GF Strong to be relocated to the VGH site. (See rehabilitation services review, next page)

D Service Alignment Strategy (continued)

- Participate, along with the Provincial Health Services Authority and other Health Authorities, in provincial planning process for rehabilitation services. Mandate for planning process should be set through the Leadership Council; anticipate an 8 - 12 month timeframe for completion of the plan.
- Subject to further direction from that provincial process, programs and services currently located at GF Strong might be transferred as appropriate to a renovated and expanded Banfield Pavilion on the VGH Site. GF Strong site would no longer be utilized and the value of land/building would be realized to support the changes.

The principal advantages of this potential option are as follows:

The UBC Hospital

- Potential to generate operating costs savings.
- Enhances and improves the concentration of patient programs/services at VGH.
- Enhances and improves the concentration of tertiary services for patients at VGH.
- Potential to improve the relative proportion of medical and surgical beds at VGH.
- Increases the critical mass at VGH to support teaching programs, reduces the diffusion of teaching programs across sites.
- No adverse impact on research activities anticipated, in fact the vacated space at the UBC site could help address a need for additional research space.
- Potential for private partnership arrangement to utilize UBC Koerner Pavilion for some surgical volumes.
- Potential for private partnership arrangement to develop urgi-care services at UBC Koerner Pavilion.
- Reduces the infrastructure and support services required for acute services.
- Consistency with indicated direction of increased regional responsibility for patient populations i.e. anticipate strong directives to move secondary activity from Vancouver hospitals for non-residents to other regions.

The principal advantages of this potential option are as follows:

GF Strong

- Natural linkages with acute care services including spine and neurosciences that are a major referral source; opportunities to improve the range and continuity of services for this patient/client population.
- Opportunities for shared services.
- Easier access for patients to acute medical support including radiology and laboratory.
- No need to create stand-alone diagnostic facilities.
- Consistent with vision for comprehensive academic health campus at VGH site.
- Excellent access to transportation for patients and clients who have physical disabilities that make use of private and public transport.
- Potential to share existing research space.
- Potential to link more closely with entrepreneurial activities drawn to VGH site.
- Synergy with the Brain and Spinal Cord Centre and other potential research enterprises, Spinal Research Centre.

In addition to improvements in care and service for patients and clients, the saving from relocation of acute services from UBC Hospital is conservatively estimated at $4.7 million. Future savings (beyond this 2002-05 plan) of $3.1 million are estimated in relation to relocation of GF Strong. It is useful to have a sense of the order of magnitude of the savings associated with the possible relocation of UBC Hospital

D Service Alignment Strategy (continued)

services. It should be noted that they are equivalent to approximately half of all the acute Reductions ($9.5 million) that remain in the VHHSC plan and are approximately equal to the total current cost of perioperative services at the hospital.

D2 Providence Legacy Project: A Vision of Renewal

The Providence Legacy Project (PLP) provides a blueprint for significant redesign of Providence Health Care (PHC). It is predicated on significant clinical consolidation, facility renewal and land asset redevelopment to accommodate new care delivery models for an aging population. PHC believes this plan will be critical in renewing our organization's ability to deliver patient and resident care well into the new century.

The PLP was developed and created with input from The PHC Board, executive team and leadership. It has received written approval and support from the Providence Health Care Society, Board of Directors and the Founding Congregations. It has also been shared with representatives from the Vancouver Coastal Health Authority, the Ministries of Health Services, Health Planning and Finance, as well as the City of Vancouver. Response has been very positive.

Providence Health Care presents the Providence Legacy Project outlines an exciting and actionable future for the health system of British Columbia. Providence Health Care is confident in its leadership capacity to realize this plan.

The Providence Legacy Project

- Consolidate acute and rehabilitation services from four sites onto two.
- Optimize clinical efficiencies and outcomes by creating a critical mass of similar work.
- Reinforce our commitment to teaching and research by providing expanded research space and needed infrastructure improvements.
- Improve physical working environments for our staff, physicians and volunteers.
- Consolidate residential care from seven sites onto three.
- Leverage Providence land assets for strategic capital investment.
- Maximize public-private partnership opportunities for facility renewal and redevelopment.
- Ensure operational efficiencies and cost effectiveness while maximizing service levels and access to services.
- Contribute to VCHA's successful realignment of health care services through voluntary consolidation.
- Support strategic public reinvestment into innovative care models such as aging in place, independent living, assisted living, and specialized residential care services including complex care, chronic behaviour disorders and Geriatric Venture.

Operational efficiencies of about $3.5 million are attributed to the PLP site consolidation.

PHC St. Paul's Hospital (SPH)

St. Paul's Hospital is Providence Health Care's academic acute care hospital serving an urban and provincial population. The PLP strengthens its role by consolidating at St. Paul's Hospital all of St. Vincent's specialized surgical services (including related operating room, inpatient and ambulatory activity) and Holy Family Hospital's specialized rehabilitation services (including related inpatient and ambulatory activity). While Providence acknowledges that government is committed to the Vancouver Hospital tower project, the addition of renewal at SPH will completely revitalize the two academic adult health care centres in the province.

D Service Alignment Strategy (continued)

PHC Mount Saint Joseph Hospital (MSJ)

Mount Saint Joseph Hospital is Providence's community acute care hospital. The Providence Legacy Project expands the hospital's role in providing care to elderly patients with complex physical and psychological needs by consolidating all of St. Vincent's geriatric services on this site. It supports MSJ's role in serving the acute and ambulatory care needs of a multicultural patient base and residents of Vancouver's east side. As well, it enables the full development of a 24-hour emergency department and strengthens MSJ's role in the provision of secondary surgery by consolidating all general surgery from St. Vincent's on this site. There would also be opportunities for expanded health discipline education to meet the teaching needs of UBC and other academic partners. With this ambitious consolidation within the Vancouver Coastal Health Authority, MSJ can be the "pressure relief valve" for both VCHA and Providence.

PHC St. Vincent's Hospital, Heather (SVH)

St. Vincent's Hospital, Heather is Providence's acute care hospital specializing in chronic disease management and care for the complex elderly. The redevelopment plan includes:

- Consolidation of acute activity to the SPH and MSJ sites.
- Redevelopment of the SVH site for aging in place models, with independent living and assisted living environments.

PHC Holy Family Hospital (HFH)

Holy Family Hospital is Providence's tertiary rehabilitation hospital providing specialized inpatient and ambulatory rehabilitation care. It also houses extended care services. The plan includes:

- Consolidation of redesigned rehabilitation services at SPH.
- Redevelopment of the site for aging in place models, with diverse housing and support options for seniors and other groups.

PHC Residential Care

Providence's current configuration of residential care services includes a mixture of intermediate and extended care across seven sites – Youville Residence, St. Vincent's, Heather, Arbutus and Langara, Mount Saint Joseph, Holy Family and Brock Fahrni. For the most part, The PHC residential care services are located in aging facilities that do not meet current environment standards, nor facilitate current care philosophies.

The Providence Legacy Project maximizes best available residential care space. It aggressively pursues.

- Providence-led redesign of the PHC residential care services to enable opportunities for specialized services such as chronic behaviour disorder, Geriatric Venture and complex care.
- Public-private partnerships for facility redevelopment.
- Public and private reinvestment for aging in place models, including independent living and assisted living.

D Service Alignment Strategy (continued)

The Providence Health Centre residential care redevelopment plan includes:

- Continuation of Youville's multilevel care capacity, with the development of aging in place models and specialized residential services (within the already approved development permit for 72 additional beds).
- Continuation of Brock Fahrni's extended care capacity with an emphasis on serving war veterans.
- Maximum use of our best residential care environment at Langara, with the addition of 19 beds.
- Elimination of residential services at SVH, followed by site redevelopment to create aging in place models, including independent and assisted living for residents requiring the lowest degree of personal care.
- Elimination of residential care services at Arbutus, leaving the site available as an asset of Providence.
- Elimination of the residential capacity at HFH.
- Eventual elimination of the residential capacity at MSJ.

E Revenue Generation

Across VCHA, approximately $7 million in revenue generation opportunities have been identified primarily in acute care. The plan includes business-to-business initiatives, retail/space rental, room amenities, activation of clinical equipment/clinical space, increases in outpatient services that generate technical fees and some cost recovery and user fees. Where user fees will further enhance or supplement patient care, and are in keeping with the *Canada Health Act*, they will be considered as well.

F Service Alignment Strategy – Acute Care

The plan for Vancouver Acute services identifies and removes a proportion of secondary/out of region cases. After some reinvestment in the budget plan, this strategy accounts for a 3.9 percent - 4.6 percent reduction in patient days, 7.8 percent - 9.0 percent reduction in inpatient surgeries and a 20 percent reduction in same day surgery. As part of the acute system in Vancouver, this approach was also a consideration in the Providence Health Care plans.

- A 'Care, Support and Service Team' was asked to examine service priorities with the following intent: Given the expectation that we will need to reduce services as one of the operational planning strategies, how can we make the best choices?
- The team concluded that whereas tertiary and regional services were generally congruent with our core mission, the delivery of secondary services to non-residents of the region was a better fit with the missions of those regions than of ours. They then considered utilization equity (i.e., the level of access to secondary services to residents of all parts of the province) and concluded that potential reductions in secondary services for non-residents should be considered reductions from the system rather than transfers to other regions. All other regions have much higher access to secondary services than ours, and it was felt that other regions should need to make more of the choices regarding appropriate indications for service that we have already needed to make for our residents. **Residents of all other regions would still have significantly higher access to secondary services than residents of this region.**
- The model the team used was specifically developed with adjustments to accommodate all cases that were considered tertiary by either the BC or Ontario methods, or were for commuters, or were for cancer, obstetrics, newborns or abortions.
- This information is intended to guide the actual funding changes that will be made, but clinical judgement will still determine how to handle individual cases within the volume and resource constraints.

We will need to communicate this strategy to the other health authorities, to our physicians and program leaders and to the public. In a time of system transformation, all regions are challenged to meet high levels of appropriateness of acute care. Our utilization in the urban areas is 68 - 76 cases per 1,000 population, with all other regions being at least 20 percent higher in their utilization. With this in mind, and given the literature reviewed, 70 - 75 cases per 1,000 seems appropriate as a "best practice" utilization target. Therefore other regions are expected to consider their strategies for appropriate services, and to begin to reduce their cases per 1,000 population. Even after budget management plans are in place in other regions, there will still be a significant discrepancy. Other regions will be able to accommodate those secondary needs of their residents that we cannot, within their higher levels of capacity, with a modest movement towards our standards of indications for admission. In effect, the changes we are planning above would result in a reduction of less than 2 cases per 1,000 population in any other Health Service Delivery Area.

It is instructive to look at this strategy in relation to two other significant policy directions of the Ministry and other regions, appropriate utilization and self-sufficiency. Consider the Fraser Health Authority, which is our closest and largest neighbour and accounts for over 60 percent of the caseload reduction identified though this strategy. Our strategy will account for a reduction in cases per 1,000 population of about 1 to 1.5 in the three Fraser Health Authority HSDAs. Suppose instead, that the Fraser Health Authority decided to move towards a target utilization level of 75 cases per 1,000 population and suppose they asked us to maintain our referral share and reduce our volumes proportionately.

F Service Alignment Strategy – Acute Care (continued)

In that case we would reduce by about the same amount as proposed by our current strategy. Second, suppose instead that they held their current utilization rates and asked us to decrease our referral share to the share we hold for the Interior, and shift the difference to them.

In that case we would reduce by between 3 and 7.5 cases per 1,000 population for the three HSDAs. Third, and most probable over time, suppose they did both. In that case we would reduce by between 4 and 8.5 cases per 1,000 population for the three HSDA. That is over 5 times the change we are planning. There are two points to this discussion. First, the change proposed by this strategy is reasonable and even inevitable.

Second, it is the beginning of a longer reduction in secondary referral volume associated with non-residents of the region.

In addition, we will continue to work to reduce the extent of these Reductions. We will encourage our physician leaders, managers and staff to exceed the current utilization management targets based on national averages, and to reach targets achieved by the top performing organizations, in order to minimize this reduction in services. Any future changes in referral share will be explored in collaboration with the other health authorities.

Summary Acute Care (pgs 9-19)

Acute care strategies account for the following amounts by organizational entity:

	Clinical Efficiencies	*Service Alignment*	*Revenue Generation*	*Reduction*	*Totals*
North Shore/Coast Garibaldi	4,668,970	0	1,532,530	304,000	6,505,500
Vancouver Acute	16,848,000	4,731,000	3,314,000	8,860,000	33,753,000
Vancouver Community	0	0	0	0	0
Richmond	1,516,000	0	621,600	1,049,000	3,186,600
Providence Health Care (incl. Acute Mental Health)	7,768,000	See Support and Administration*	0	1,126,000	8,894,000
Totals	30,800,970	4,731,000	5,468,130	11,339,000	52,339,100
Percentages	58.8%	9.0%	10.4%	21.7%	

* The Service Alignment savings for Providence Health Care appear under Support and Administration because they relate to multiple sectors.

G Clinical Efficiencies - Continuing Care Residential and Community

- Putting patients at the top of the list in the health care system means finding better ways of doing things, and making better use of resources so that patients get the care they need. Clinical efficiencies in acute areas like the operating room, and community areas like home support and residential care will produce lasting benefits to patients, and are a central feature of our health care redesign.

- These same efficiency gains will be achieved in the area of ***home support***. Previously, home support agencies supplied home care services across the region, requiring home support workers to spend more time in their cars than with patients who needed their care. As well, the number of providers consumed significant administrative resources that should have gone to patient care. Our plan will see home support workers targeted to a smaller geographic area, meaning more service for patients. As well, we will work with fewer firms in order to reduce our administration costs and to secure the best patient value for our home support dollars.

- Clinical efficiencies will also bring benefits in ***residential care***. Traditionally, when seniors experienced a decline in their physical and mental functioning, they moved to residential care — even if they didn't need the full range of supports of residential care. Our approach favours seniors getting the care they need, by ensuring that seniors have the supports they require in their homes and their community where they can maintain their independence. We will develop assisted living facilities where supports are available for seniors as needed, and independence is maintained.

G1 Continuing Care Residential and Community Sectors - Vision

The following is a preliminary vision statement drawn from the continuing care renewal plans of the previous organizations and the province. It represents key design principles that we will continue to refine in our future work.

Community services are part of an integrated continuum of care and support the effective and efficient transition of individuals between different levels of care, service providers, organizations, and geographic locations. Programs incorporate effective, efficient and appropriate services that improve health and the quality of life.

Services are client-centered, user-friendly, easily accessed and provided in a coordinated way in people's own homes and in community service delivery centers (consistent with cost-effective and high quality care).

Individuals have the support and health services that enable them to live independently or interdependently as valued members of their community.

Services are targeted at specific health outcomes and populations especially populations at high risk of poor health.

G2 Augmentation of Assisted Living and Reduction of Residential Capacity

There are preliminary plans in this region and across the province to support increased independence for the elderly and people with disabilities by emphasizing community-based alternatives such as assisted living, home support and adult day care rather than defaulting to residential care. A regional process is being initiated to design and implement this vital initiative. The Health Service Redesign Plan and Budget Management Plan anticipate that work and begin to redirect resources from residential care to invest in augmented complex care and assisted living. In addition, provincial comparisons indicate that Vancouver is significantly above the average in the use of residential care.

G Clinical Efficiencies - Continuing Care Residential and Community (continued)

This plan begins to progressively reduce that differential for good and sufficient reasons – keeping people in the community and appropriately supported. It is also expected that there is sufficient capacity in the continuing care community sector to absorb the initial phase of that reduction. The transition will need to be carefully timed and managed to avoid compromise to the care of current residents.

- On the North Shore, there are 399 PC/IC1/IC2 clients (i.e., those with lower levels of care requirements). The budget management plan will reinvest in community and residential care, and increase service capacity for seniors (e.g., additional Adult Day Care spaces, implementation of the remainder of the Continuing Care Renewal plan, community grants, Special Care unit, and services to support the provision of complex care in the facilities - part of government Residential Care Access Policy). The plan assumes a reconfiguration of a 150-bed intermediate care facility on the North Shore to a combined assisted living/multi-level care facility. On the North Shore, 160 assisted living units will be developed over the next 18 months. Resources will be reallocated to support assisted living and complex care through the closure of a minimum of 200 residential beds. Resources will also be reallocated towards assisted living and complex care through the closure of an 81-bed Intermediate Care facility in Coast Garibaldi.

- The plan incorporates a reduction of 30 beds in the portion of residential care formerly part of VHHSC (Purdy Pavilion at UBC Site and George Pearson Centre) along with a reduction of 18 beds in the Discharge Planning Unit (from 46 beds to 28) and a clinical efficiency through the relocation of the unit from Acute to Residential setting with corresponding changes to client base and practice pattern.

- Vancouver Community is beginning to plan for budget-neutral conversion of a portion of its above-average residential capacity toward community alternatives.

- While providing a base for renewed services for the elderly, as noted above under the Providence Legacy Project, PHC expects to reduce its residential capacity by 149 beds. The planning project identified above will develop short-term initiatives to facilitate the transition and to design the long-term solutions for the city and the region.

Each of the entities considered opportunities for efficiencies in the residential and community services sector. Particular cost savings were identified in Vancouver Community services and Richmond. For example, clinical efficiencies will be achieved by minimizing case management and therapist services without reducing client volumes.

In addition, funding for contracted services is being frozen at 2001/02 levels and agencies are expected to identify efficiencies.

At the time of preparing the budget management plan, $800,000 in home support Reductions were expected on the North Shore/Coast Garibaldi. As a result of continued redesign planning, it is now expected that this can be achieved through clinical efficiencies such as staff mix and scheduling without reducing service volumes.

Reductions in Home and Community Care are being identified where service levels exceed the provincial average utilization rates, as in home rehabilitation and possibly adult day care, although the latter is being reviewed.

The reduction identified in the Community sector in Richmond is primarily a reduction in home support hours which will be accomplished through a thorough review and targeting in relation to client needs. However, while the projected home support hours are less than expected for 2001/02, it is still more than the 1999/2000 baseline identified.

Summary of Continuing Care Residential and Community (pgs 21-22)

In summary, these strategies account for the following amounts by organizational entity:

Community	*Clinical Efficiencies*	*Revenue Generation*	*Reduction*	*Totals*
North Shore/Coast Garibaldi	2,135,670	50,000	951,830	3,137,500
Vancouver Acute	0	0	0	0
Vancouver Community	1,816,725	0	1,089,059	2,905,784
Richmond	713,000	0	350,000	1,063,000
Providence Health Care	0	0	0	0
Totals	4,665,395	50,000	2,390,889	7,106,284
Percentages	65.7%	0.7%	33.6%	

Residential	*Clinical Efficiencies*	*Revenue Generation*	*Service Reduction*	*Totals*
North Shore/Coast Garibaldi	4,587,660	0	29,460	4,617,120
Vancouver Acute	2,606,000	0	1,660,000	4,266,000
Vancouver Community	1,900,000	0	0	1,900,000
Richmond	1,288,405	0	0	1,288,405
Providence Health Care	225,000	0	3,925,000	4,150,000
Totals	10,607,065	0	5,614,460	16,221,525
Percentages	65.4%	0.0%	34.6%	

H Mental Health Sector

Vision

The following statements are a synthesis from the vision and guiding principles for the mental health system in Vancouver, Richmond, the North Shore and Coast Garibaldi and from the provincial mental health plan with which the individual plans resonate strongly. We will continue to refine a regional vision and implement best practices in mental health.

Mental health services will continue to seek to improve functioning and quality of life for adults and older adults with serious mental disorders, and for children and youth and their families where significant emotional, psychological, and/or behavioural disturbance indicates the need for psychiatric treatment.

Our vision is to provide care in a timely, respectful way with sensitivity to age, gender, ethno cultural background, geographic location and lifestyle. Comprehensive, regionally and locally integrated programs and services are based on an objective of optimum recovery that respects individual's strengths, life circumstances and capacity to recover. In addition, early identification and intervention in the course of illness will prevent or mitigate long-term disability. Improving the linkage with enhanced addiction services is also a priority.

Core services, in line with provincial and federal standards of best practice, include: early intervention and prevention, assessment and triage, in- and out-patient treatments (including assertive community treatment and case management for adults and older adults, and end-of-life care for older adults), rehabilitation (personal life, leisure, education, and vocational support), housing, caregiver support and education, crisis / emergency services.

We will seek to continually evaluate and improve each service with regard to accessibility, client-centred care, continuity of care, effectiveness, efficiency, and a positive work environment.

Budget Management

Considerable work has been done in mental health planning and plan implementation in each of the organizations prior to merger. This work is continuing. However, the following initiatives focus on budget management. (No specific adjustments have been made to date to provide capacity for Riverview replacement services.)

A number of cost saving strategies have been developed in the individual entities, most being a blend of clinical efficiency and service reduction.

- On the North Shore, a number of community grants for services other than housing will be discontinued.
- Plan assumes closure of 15 psychiatric beds in Vancouver Acute, (7 more than at present) approximately half due to improved utilization management.[1]
- In Vancouver Community
  - Achieve efficiencies and reduce services in Older Adult, Adult and Child/Youth Mental Health teams.
  - Achieve efficiencies and reduce services in Mental Health Rehabilitation and Recovery Programs.
  - Realign resources to close 67 Mental Health residential care beds and offset with 80 supported independent living units.
  - Close supported employment programs; reduce drop-in centre hours.

[1] It is expected that this strategy will be minimized or eliminated through an allocation of about $700,000 from contingency funds.

H Mental Health Sector (continued)

- Richmond freeze Care Home contracts at 2001/02 levels.
- Richmond Older Adult Psychiatry 5 North Closure — achieve savings net of reallocation to Home Based Treatment.

The Mental Health strategies account for the following by organizational entity:

	Clinical Efficiencies	*Revenue Generation*	*Reduction*	*Totals*
North Shore/Coast Garibaldi	400,000	0	694,000	1,094,000
Vancouver Acute	672,000	0	608,000	1,280,000
Vancouver Community	2,996,815	0	892,506	3,889,321
Richmond	794,800	0	99,000	893,800
Providence Health Care (see Acute)	0	0	0	0
Totals	4,863,615	0	2,293,506	7,157,121
Percentages	68.0%	0.0%	32.0%	

I Health Promotion/Illness Prevention/Harm Reduction Strategy

- The fifth strategy in our health care redesign is one that has marked our approach to health care since its earliest days. Health promotion, illness prevention, and harm reduction have always been a part of health care. The need for our redesign of the health care system makes these features more important and vital than ever before.
- **The need for the promotion, prevention, and reduction approach is most evident in our Aboriginal community.** At present, an adult male Aboriginal has a life expectancy 17 years below the average. Our aboriginal strategy saw us complete "Healing Ways," a Vancouver aboriginal health report. This distressing report revealed that the health status data for the aboriginal community is lower than average in all measures. Our approach will see us work with aboriginal families to ensure they have the tools they need to raise healthy children. These and other approaches will reduce the aboriginal health challenges and preserve health funding for additional targeted purposes within the aboriginal community.
- British Columbia's **Downtown Eastside**, located in the VCHA, continues to lead the nation in every negative measure, including health. Our health care redesign will see us ensure that health dollars are better orchestrated and are targeted to the best use in the community. This means we will put more primary care into the community including more contact and referral centres. As well, we are creating an evaluation plan to ensure that our efforts in health promotion, illness prevention, and harm reduction play an effective role in reducing the Downtown Eastside interaction with the health care system in the short- and long-term.

I1 Vision for Public and Preventive Health and Primary Care

The entities that make up the VCHA have a strong history of emphasizing public and preventive health and primary care.

The most recent health and service plans from the previous organizations included the following priorities, particularly in relation to health promotion, illness prevention and harm reduction.

From Vancouver/Richmond plans:

- Increase years of life and improve quality of life, particularly for those experiencing disparities in health status.
- Promote and advocate with other sectors for improvements in health status through the action of the broader determinants of health.
- Improve access to appropriate care, with particular attention to (five components, including) an improved primary health care system, which includes effective health promotion and disease, disability and injury-prevention programs.

From the North Shore plans:

- Maximize the healthy growth and development of children 0-5.
- Improve the health of people who experience significantly poorer health status than the norm for the region.

From Coast Garibaldi area plans:

- Reduce inequalities in health status and health service delivery.
- Promote health.
- Reduce preventable diseases and deaths.

I Health Promotion/Illness Prevention/Harm Reduction Strategy (continued)

I2 Related Initiatives

Initiatives being implemented from on previous planning documents for these areas include:

- Implement Healing Ways and plan an Aboriginal Healing Centre in Vancouver, and develop health profiles and dialogue regarding plans with Aboriginal peoples across VCHA.
- Implement the Integrated Health Approach for the Downtown Eastside, particularly the opening of four sites to expand primary care and addiction services in concert with the Vancouver Agreement involving all levels of government.
- Develop partnerships to increase knowledge and skills of parents and caregivers in relation to early child development.
- Implement strategies to improve the health status of people with HIV/AIDS.
- Encourage healthy lifestyle choices in relation to smoking, substance misuse, physical activity, nutrition and sexual practices.
- Reduce or maintain low levels of vaccine preventable diseases.

The VCHA will continue to emphasize public and preventive health and primary care, particularly by continuing to develop and implement strategies that:

- Increase years of life and improve quality of life, particularly for those experiencing disparities in health status.
- Maximize the healthy growth and development of children 0-5.
- Apply effective prevention strategies.
- Improve the management of chronic health problems.
- Avoid and shorten hospitalization.

I3 Budget Management

The individual strategies for North Shore/Cast Garibaldi and Richmond are comparatively small. In Vancouver Community Public and Preventive Health[2], the major initiatives contributing to some clinical efficiencies and to reductions were:

- Eliminate infant, child and youth vision screening and treatment programs.
- Reduce by 50 percent the child and youth audiology and dental screening and treatment programs, focus on high needs clients.
- Decrease community health nursing targeting elementary school entry.
- Eliminate portion of community capacity projects (SMART fund projects - $700,000 reduction).
- Minor reduction in scope of services in Primary Care clinics (Service Reduction).
- Realign resources within Downtown Eastside/HIV programs to achieve efficiencies and increase utilization of enhanced primary health services (Clinical Efficiency).

[2] It is expected that these reduction strategies will be reduced through an allocation of about $300,000 from contingency funds.

Summary of Public and Preventive Health and Primary Care

The Public and Preventive Health sector is the largest of our direct service sectors responsible for the health promotion, disease, disability and injury prevention and harm reduction strategies. **The financial results for this sector account for the following amounts by organizational entity.**

	Clinical Efficiencies	*Revenue Generation*	*Reduction*	*Totals*
North Shore/Coast Garibaldi	50,000	10,000	182,000	242,000
Vancouver Acute	0	0	0	0
Vancouver Community	500,101	0	3,170,996	3,671,097
Richmond	233,000	149,000	166,000	548,000
Providence Health Care (see Acute)	0	0	0	0
Totals	783,101	159,000	3,518,996	4,461,097
Percentages	16.7%	3.4%	75.2%	

The Primary Care strategies relate to only the Vancouver Community entity.

	Clinical Efficiencies	*Revenue Generation*	*Reduction*	*Totals*
Vancouver Community	1,015,933	0	57,751	1,073,684
Percentages	94.6%	0.0%	5.4%	

J Operational Efficiencies Strategy

- Each dollar we put into the system must do as much as it can for patients. It is essential that we deliver health services in a cost-effective and sensitive manner that recognizes the needs of patients and taxpayers. Our action in generating operational efficiencies in administrative service and infrastructure will ensure support and resources for front-line caregivers.

- The VCHA has taken the first step in generating operational efficiencies **by reducing executive-level positions by 25 percent, and reducing management staff by 14 percent**. Moreover, the new executive team is accountable for achievement of defined objectives and collective goals, an important component to the effort to put patients and their care at the top of the list.

- Another operational efficiency will be gained through use of alternative and shared service delivery, as in the example of the cleaning of non-patient areas such as administrative offices, research areas, and doctors' offices. By using the alternative service model, we will reduce the dollars spent on cleaning. Through effective use of shared services, we will further reduce spending on such non-patient operations by negotiating cost-effective contracts that cover multiple facilities. The resulting reduction in management time spent on non-patient service will yield additional savings. In all, VCHA action on alternative and shared service efficiencies will produce $40 million that will be used to protect patient services and care.

J1 Support and Administrative Service Sector

The VCHA is in the process of rolling its financial and staffing information into the Administrative and Support categories for which the Ministry has recently provided a standard definition. At this point, we have presented the information according to functions that are part of the most readily identifiable related departmental groupings, along with the discussion of all Shared Services in this category. While this may not yet precisely match the new definitions, it is expected to be substantially the same.

J2 Shared Services Initiative

Process for Implementation

The Shared Services Initiative encompasses thirty-two businesses with net expenses totaling over $460 Million and employing over 5600 staff. The businesses included in the initiative are those which are diagnostic, therapeutic, support or administrative in function. The entities that are included in the initiative include all direct service of the Vancouver Coastal Health Authority, Providence Health Care, and contracted long-term care facilities and in-home care services located throughout the VCHA. In addition to these organizations, the B.C. Cancer Agency and Children's & Women's Hospital of B.C. are working with the Shared Services Team to identify any opportunities for inter-regional sharing of services.

J Operational Efficiencies Strategy (continued)

Stage 1: Identification of Businesses to be Included in the Initiative

The businesses to be included in the Shared Services Initiative are identified below:

1. Diagnostic Lab
2. Diagnostic Imaging
3. Pharmacy
4. Plant Maintenance / Operations
5. Nutrition Services
6. Information Systems
7. Housekeeping
8. Finance
9. Human Resources
10. Health Records
11. Laundry/Linen
12. Material Management
13. Research
14. Other
15. Social Work
16. Planning
17. Physiotherapy Admitting
18. Respiratory Therapy
19. Security
20. Biomedical Engineering
21. Occupational Therapy
22. Other Therapies
23. Switchboard
24. Telecommunications
25. Communications
26. Volunteer Resources
27. Pastoral Care
28. Speech Therapy
29. Quality Assurance
30. Utilization Management
31. Diversity

Twelve businesses to achieve the majority of the defined savings of $3 Million in 2002/2003, $29 Million in 2003/2004, and $8 Million in 2004/2005.

The businesses to be included in the Shared Services Initiative are not limited to the businesses identified above. However, these 32 businesses will be the primary focus of the Shared Services Team to meet the identified targets over the next three years. On the following page is a table outlining the revenue, labour, non-labour expenditure, and full time equivalents within each of these businesses.

Stage 2: Assessment of Businesses

The assessment of the businesses included in the Shared Services initiative is currently underway. Best practice partner organizations are being identified, the key considerations for successful implementation are being documented and business leaders are singling out components and enablers required for successful implementation. These leaders are assessing the opportunities associated with the continuum of alternate service delivery (ASD), from insourcing to outsourcing.

In addition to the meetings being held with the business leaders, members of the Shared Services Team are conducting external assessments of market capacity issues for private sector providers.

J Operational Efficiencies Strategy (continued)

The team is identifying the capability of the private sector to provide the level and quality of service required by the organizations. Furthermore, the team is assessing the industry structure to ensure maximum competition amongst the private providers.

Stage 3: Identification of High-Level Implementation Timelines

High-level implementation timelines have been established with the action plan for the Shared Services initiative to be completed within 90 days. Meetings with the business leaders are being held weekly and are expected to be completed by the end of June 2002. The business leaders will subsequently meet with the Shared Services Team (no later than 6 weeks following the initial meeting) and provide their assessment of the opportunities within their respective businesses, the ASD model which will provide maximum operational and financial return, and the enablers and barriers to successful implementation.

Stage 4: Identification of Common Performance, Quality, and Workload Measurement Indicators

In addition to the opportunities for operational and financial return, the business leaders are being asked to identify common performance, quality and workload measurement indicators. These indicators are essential for staging the current situation and measuring the success of the initiative. The indicators will be measured by all organizations participating within the shared services initiative.

Stage 5: Defining Single Point of Accountability

Upon completion of the assessment of the business, the Shared Services Team will identify a single point of accountability for the business. This individual will be responsible for the successful implementation of the shared services project.

J Operational Efficiencies Strategy (continued)

Shared Services Initiative

Description	Revenue	Labour	Non-Labour	Total Expenses	Net Expenses	FTE's
DIAGNOSTIC LAB	($17,542,699.67)	$54,156,283.02	$14,454,459.74	$68,610,742.76	$51,068,043.09	663.46
DIAGNOSTIC IMAGING	($21,200,547.38)	$43,985,234.12	$26,327,975.48	$70,313,209.60	$49,112,662.22	514.34
PHARMACY	($8,580,537.04)	$19,848,641.70	$31,966,392.22	$51,815,033.92	$43,234,496.88	311.35
PLANT MAINTENANCE / OPERATIONS	($685,623.11)	$16,019,790.73	$40,156,877.23	$56,176,667.96	$55,491,044.85	294.43
NUTRITION SERVICES	($6,683,356.01)	$36,551,124.42	$12,859,326.19	$49,410,450.61	$42,727,094.60	806.81
INFORMATION SYSTEMS	($375,889.30)	$18,217,760.25	$25,194,862.71	$43,412,622.96	$43,036,733.66	222.68
HOUSEKEEPING	($77,701.97)	$30,186,956.13	$2,831,523.70	$33,018,479.83	$32,940,777.86	720.72
FINANCE	($772,243.78)	$15,282,693.45	$2,151,873.03	$17,434,566.48	$16,662,322.70	249.62
HUMAN RESOURCES	($366,106.72)	$14,241,699.24	$3,340,613.53	$17,582,312.77	$17,216,206.05	243.81
HEALTH RECORDS	($291,374.93)	$11,185,679.56	$993,545.73	$12,179,225.29	$11,887,850.36	232.77
LAUNDRY/LINEN	($1,461,713.06)	$8,342,854.54	$4,921,237.23	$13,264,091.77	$11,802,378.71	196.14
MATERIAL MANAGEMENT	($280,457.88)	$8,412,708.19	$1,920,790.48	$10,333,498.67	$10,053,040.79	151.30
RESEARCH	($206,664.29)	$8,740,289.92	$1,461,338.72	$10,201,628.64	$9,994,964.35	33.52
OTHER	($210,477.62)	$7,865,282.32	$2,801,064.79	$10,666,347.11	$10,455,869.49	150.01
SOCIALWORK	($13,518.00)	$5,463,099.75	$44,925.00	$5,508,024.75	$5,494,506.75	80.40
PLANNING	($87,144.95)	$5,296,947.88	$2,682,373.59	$7,979,321.47	$7,892,176.52	76.48
PHYSIOTHERAPY	($47,351.00)	$6,303,238.26	$137,218.73	$6,440,456.99	$6,393,105.99	102.53
ADMITTING	$0.00	$5,904,356.56	$300,824.59	$6,205,181.15	$6,205,181.15	123.17
RESPIRATORY THERAPY	($362,298.00)	$3,384,620.06	$571,182.07	$3,955,802.13	$3,593,504.13	50.75
SECURITY	($831,286.05)	$5,234,137.47	$385,614.56	$5,619,752.03	$4,788,465.98	110.74
BIOMEDICAL	($3,539.96)	$4,178,514.97	$1,314,641.62	$5,493,156.59	$5,489,616.63	67.54
OCCUPATIONAL THERAPY	($156,898.00)	$4,732,223.90	$216,022.97	$4,948,246.87	$4,791,348.87	78.61
OTHER THERAPIES	($709,534.00)	$4,386,997.61	$365,969.01	$4,752,966.62	$4,043,432.62	61.99
SWITCHBOARD	($17,742.00)	$2,815,606.62	$205,261.13	$3,020,867.75	$3,003,125.75	60.31
TELECOMMUNICATIONS	($122,198.00)	$631,357.99	$619,282.93	$1,250,640.92	$1,128,442.92	8.20
COMMUNICATIONS	($1,600.00)	$937,194.71	$259,512.07	$1,304,866.42	$1,303,266.42	13.79
VOLUNTEER RESOURCES	($3,747.00)	$1,025,737.69	$294,391.22	$1,320,128.91	$1,316,381.91	18.81
PASTORAL CARE	($53,771.00)	$1,322,758.90	$39,047.00	$1,361,805.90	$1,308,034.90	23.40
SPEECH THERAPY	($1,700.00)	$614,450.09	$9,040.22	$623,490.31	$621,790.31	8.57
QUALITY ASSURANCE	($3,200.00)	$316,984.42	$44,052.00	$361,036.42	$357,836.42	4.00
UTILIZATION MANAGEMENT	$0.00	$537,033.16	$106,950.00	$643,983.16	$643,983.16	5.60
DIVERSITY	$0.00	$242,908.07	$126,029.00	$368,937.07	$368,937.07	3.90
TOTAL	($61,150,920.72)	$346,365,165.70	$179,104,218.49	$525,577,543.83	$464,426,623.11	5,689.76

Stage 6: Business Level Implementation of Initiative

The implementation of the shared services initiative will vary according to the business and the complexity of the initiative. Implementation will begin with those businesses providing the largest return, not requiring major capital investment, and are not associated with direct patient care. The businesses that are being assessed immediately include Plant Operations, Retail Food Services, Housekeeping, Laundry, Logistics (Purchasing and Inventory Control), and Security Services. Alternate service delivery models for these businesses are being established and should be completed within the next 90 days.

J3 Executive Team and Management Restructuring

A dramatic convergence of social, political, economic, demographic and technological forces have brought the Vancouver Coastal Health Authority to the threshold of a new era in health care. It is expected that the VCHA will adopt a more accountable, business-oriented approach in order to deal more effectively and efficiently with the many opportunities and challenges it faces. To be successful,

J Operational Efficiencies Strategy (continued)

it is vital that all components of the new VCHA system commit to and align with the core strategic objectives identified for VCHA.

Meeting the challenges of restructuring will require collaboration and creativity from all our staff, physicians and partners. A first step in this very important journey began with the restructuring of the senior executive team. Our new team brings together representation from all geographic and clinical areas of the Authority to encourage a commitment to integration, accountability and patient care.

Every portfolio of the senior executive team was designed to promote a systems approach to the integration of services throughout the Vancouver Coastal Health Authority. To highlight our systems approach, we will provide the following high-level overview of the changes to leadership portfolios.

- The Chief Executive Officer (CEO for the former North Shore Health Region is now the Chief Operating Officer (COO) of Vancouver Acute.
- The former Vice President (VP) of Programs for the North Shore is now the COO for the North Shore/Coast Garibaldi Health Service Area.
- The former VP of Clinical Services of VHHSC is now the COO for Vancouver Community.
- A second former VP of Clinical Services at VHHSC is now the Chief Information Officer (CIO) for the VCHA.
- The former VP Medical Services for V/RBH is now the COO for Richmond Health Services and the Executive Medical Director for the Authority.

These portfolio changes at the operational level clearly demonstrate an integrated systems approach by moving people from acute to community and between Health Service Delivery Areas. In addition two senior corporate positions have been created: one with primary responsibility for integration of physical asset management; i.e., finance, shared services, revenue generation, facilities management. The other position brings together from a systems perspective responsibilities for people (human resources and organizational development), planning, policy, productivity improvement, performance measurement, professional practice (Chief Nursing Officer) and public consultation. Taking this systems approach to the portfolios of the senior executive team begins to send a clear message to the organization that we are moving to both vertical and horizontal integration of services.

Along with establishing this organizational design principle, we sent a second signal by reducing the size of the executive team by 25 percent.

The work of the new Team is set out through core competencies including leadership, accountability, fiscal management, quality improvement, communication and organizational/structural change enablers.

A major reduction in management positions in support and administrative services has been identified (including approximately 14 percent of management positions in the VCHA corporate area and 10 percent savings). All areas in VCHA have identified at least 10 percent non-contract staff reductions.

Providence Health Care has also revised its leadership structure, with an expected saving of eight percent.

J Operational Efficiencies Strategy (continued)

J4 Regional Corporate Services

- Consolidation of many support and administrative functions at the VCHA corporate level has been a major factor leading to the significant reduction in management positions described above. This includes consolidating human resource, finance, logistics, medical affairs, communications and planning departments across either all or components of the VCHA.
- Savings have been generated by re-designing staff support services related to human rights and day care for children of staff.
- Human Resources (HR) will begin a major initiative to establish targets that will assist the entire organization in reducing the cost of overtime, sick time and WCB incidence. The introduction of an applicant tracking system will streamline our recruitment efforts. With the success of this activity, overtime should be reduced. We will also be implementing a series of initiatives to reduce duration of sick time and incidents of injury.
- HR advertising costs will be reduced by 75 percent or $300,000. Another initiative is to better manage the granting of union leave. It is anticipated that this effort will reduce costs by $150,000.
- Improved administrative controls and business planning is expected to produce savings in consulting fees, construction project costs and purchasing.
- Academic and research departments are expected to maintain their levels of activity through efficiencies and possibly some new revenue generation from clinical trials and other revenue sources.
- It should be noted that Providence Health Care has also reduced all of its corporate departments by at least five percent.

J5 Other Support Services Efficiencies

A number of additional efficiencies have been identified beyond the strategies presented above.

- NS/CG also expects to achieve savings through further contracting out/Joint management (Aramark).
- The North Shore Plan incorporates cost reductions/efficiencies in support services (e.g., housekeeping, retail food services, linen/laundry, etc.) also including:
  - Sick time reduction.
  - Centralization & Integration of North Shore and Coast Garibaldi services.
- Vancouver Acute Plan incorporates cost reductions in support services (includes housekeeping, sterile supply; patient food services; linen/laundry etc.) associated with volume decreases of $3 million. Plan also includes an additional reduction in support services of $3.5 million before Shared Services adjustments.
- In Vancouver Community
  - Consolidate volunteer programs.
  - Reduce community and public involvement resources.
  - Complete the implementation of the community health information system in 2002-05.
- Efficiencies in Logistics and from Food Service restructuring for Richmond.
- Providence Health Care has also achieved savings by centralizing its switchboard attendant function.

J Operational Efficiencies Strategy (continued)

J6 Human Resources Strategy

The VCHA human resource plan is under development and includes a variety of objectives and strategies. A series of performance indicators and targets has been set to help guide and monitor progress towards these objectives (e.g., reduction in sick leave by 10 percent by 2003). Overall the plan is designed to enhance the quality of care, achieve "wins" for employees and improve effectiveness and efficiency of health services.

The key strategies under development are grouped into several main themes: Some of the highlights include:

Recognizing and Developing Human Resources as a Core VCHA Asset:

- A leadership-learning plan that fosters effective human resource management by all levels of management.
- Employee reward and recognition programs to celebrate successes and encourage innovation.
- Employee satisfaction and feedback initiatives to foster a positive human resource climate.
- Workplace safety initiatives including new safety committees, wellness programs and increased safety strategies such as installation of patient lifts.
- New partnership strategies with unions, associations and government to develop solutions to human resource issues.

Re-designing the Workplace:

- Reviewing work processes, re-designing staffing models and deploying staff in more effective ways to make use of their full scope of practice and competencies.
- Introducing new approaches to shared services to reduce costly duplication of work.
- Creating flexible scheduling to recognize the demographics of the workforce.

Creating Readiness for Change in the Organization:

- Measuring and monitoring progress in the human resource environment.
- Creating an awareness of the positive aspects of the VCHA human resource environment as an advantage to "brand" the VCHA as an employer of choice.
- The overall human resource plan is a dynamic document. Significant parts have been developed and implementation planning is now underway.

J7 Information Systems Development

The VCHA is committed to a significant investment in Information Systems in order to realize the benefits of the recent regionalization process. Currently the organization spends approximately 2.4 percent of its operating budget in IS. This includes the dollars for departmental as well as the corporate IS systems. There are challenges in the business system arena, the clinical system arena and the general communication infrastructure. In the business systems arena, there are issues with the existing Enterprise Resource Planning (ERP) implementations, there are a wide variety of vendors (>21), and there is no consolidated reporting mechanism. In the clinical systems arena, one HSDA (Richmond) has no viable hospital information system (HIS), there are 5 separate HIS environments in place across the HA, there are a wide variety of vendors (>23), and there are issues with the products having exceeded their supportable lifespan. In the area of infrastructure, there is no common messaging environment, there is no common set of data network services, and no secure remote access service across the HA.

J Operational Efficiencies Strategy (continued)

The VCHA is beginning its IS redevelopment with an evaluation of its structure and organizational design. This will be completed March 31. The HA is performing a system-by-system, analysis and summary which will form the basis of a strategic plan. We are analyzing different options for the business system solution (ERP) including the options of maintaining more than one system or consolidating existing services into one ERP application. Different service provider options are being considered. The plan for these options will be ready by March 19. In the mean time, we will develop a common reporting system.

A decision support environment (leveraging off the current system used at Vancouver Hospital) is under development for deployment of management information throughout the Authority- infrastructure to be in place by May 2002. In the clinical arena, we are completing the implementation of the most advanced community information system in Canada, and working to implement the integration of a locally developed mental health system within it. Phase 1 will be completed by 2003.

We are evaluating and making recommendations on a common integrated clinical information system plan in the HA. The strategic framework and assumptions will be completed by April 12. Because a large portion of our patients/clients are from outside the region, we will develop a plan for an electronic health record, using a virtual integration strategy to share our data with other HA's. We will seek partners in this project from the MoH and the VIHA as well as the private sector and will be applying for funding from Canada Health Infoway Inc. The plan will be completed by summer 2002. We will implement a common email address book and develop a plan for a common telecommunications system by summer 2002.

Summary Operational Efficiencies – Support and Administrative Services (pgs 29-36)

The Support and Administrative strategies account for the following amounts by entity. The shared services efficiencies are identified separately. These are not identified in the organizational entity summaries except for a portion of the Providence Health Care allocation that appears in that summary.

	Revenue Generation	*Shared Service Efficiencies*	*Other Operational Efficiencies*	*Service Alignment*	*Totals*
North Shore/Coast Garibaldi	0	4,900,000	8,319,460	0	13,219,460
Vancouver Acute	0	18,700,000	7,296,000	0	25,996,000
Vancouver Community	205,000	1,000,000	2,782,815	0	3,987,815
Richmond	0	2,600,000	991,600	0	3,591,600
VCHA Corporate	0	0	7,022,570	0	7,022,570
Providence Health Care	1,000,000	12,800,000*	3,200,000	3,456,000	20,456,000
Totals	1,205,000	40,000,000	29,612,445	3,456,000	74,273,445
Percentages	1.6%	53.9%	39.9%	4.7%	

* The PHC entity summary includes $8,000,000 as a shared services savings estimate. This Overview uses a subsequent estimate of $12,800,000 based on an allocation among participating entities. The final estimates and distribution will depend on further planning and agreements among the partners.

K Implications of the Health System Redesign Plan

K1 Financial Implications of Health System Redesign Plan

	*Efficiencies**	*Service Alignment*	*Revenue Generation*	*Reductions*	*Totals*	*Percentage of Total Reduction*
Acute	30,800,970	4,731,000	5,468,130	11,339,000	52,339,100	32.2%
Continuing Care Community	4,665,395	0	50,000	2,390,889	7,106,284	4.4%
Continuing Care Residential	10,607,065	0	0	5,614,460	16,221,525	10.0%
Mental Health	4,863,615	0	0	2,293,506	7,157,121	4.4%
Public and Preventive Health	783,101	0	159,000	3,518,996	4,461,097	2.7%
Primary Care	1,015,933	0	0	57,751	1,073,684	0.7%
Support and Administration	69,612,445	3,456,000	1,205,000	0	74,273,445	45.7%
Totals	122,348,524	8,187,000	6,882,130	25,214,602	162,632,256	
Percentage of Total Reduction	75.2%	5.0%	4.2%	15.5%		

* Includes Clinical Efficiencies (rows 1-6) and Operational Efficiencies (row 7, Support and Administration)

In short, it should be noted that across the VCHA, 98.7% of service will either be retained or improved as we move through our three-year redesign plan. We have developed a number of mitigating strategies and will continue to examine methods to increase efficiencies and limit these Reductions. Indeed as we implement further changes linked to future reviews, we believe we can further reduce the 1.3%.

It should be noted that the strategies in Support and Administrative services, including Shared Services, account for over 45 percent of the entire financial challenge faced by the VCHA. While precise determinations of Administrative and Support Services are being finalized, we expect to significantly exceed the required target of a 7 percent reduction in these areas.

K2 Human Resource Implications of Health System Redesign Plan

The following is a preliminary estimate of the human resource implications of these strategies in terms of FTE reductions, generally prepared by Finance staff based on salary costs per FTE. More specific determinations are being developed. The figures for North Shore/Coast Garibaldi are based on figures prepared by that group based on analysis of the detailed strategies. The Providence Health Care figures have been used except in the area of Shared Services. All Shared Service figures are based on Finance estimates and have been allocated to the operating entities.

K Implications of the Health System Redesign Plan (continued)

	North Shore/ Coast Ganbaldi	Vancouver Acute	Vancouver Community	Richmond	Corporate	Providence Health Care	Total
Acute	48.0	422.6	0	44.0	0	117	631.6
Continuing Care Community	34.2	0	77.3	18.6	0	0	130.1
Continuing Care Residential	41.0	73.3	26.0	8.6	0	97	245.9
Mental Health	3.5	16.6	59.9	12.8	0	0	92.8
Public and Preventive Health	1.8	0	45.0	6.9	0	0	53.7
Primary Care	0	0	1.6	0	0	0	1.6
Shared Services	80.4	306.7	16.4	42.6	0	210.0	656.1
Support and Administration	79.6	62.3	37.2	16.2	60.1	86	341.4
Totals	288.5	881.5	263.4	149.7	60.1	510	2153.2

K3 Quality of Care and Service Workload Implications of Health System Redesign Plan

The VCHA will continue to meet the access standards defined in *Standards of Accessibility and Guidelines for Provision of Sustainable Acute Care Services*. As documented by the Ministry, we currently meet the following levels of accessibility and do not expect these to change.

	Emergency services 24/7/52 within 1 hour	*Acute inpatient services within 2 hours*	*Core specialty services within 4 hours*
NS/CG	100%	100%	100%
- Bella Coola Valley	97.11%	87.48%	Info at HSDA level only
- Central Coast	96.60%	100%	Info at HSDA level only
Vancouver	100%	100%	100%
Richmond	100%	100%	100%
VCHA	99.99%	100%	100%
Target for HAs	98%	98%	98%
Target for HSDAs	85%	95%	95%

The following are a number of key service activity measures. Further indicators of service and quality will be provided in the next few weeks. Comparative data for the individual areas in the region and for BC appear at the end of this document.

K Implications of the Health System Redesign Plan (continued)

		Bella Bella/ Bella Coola	Coast Garibaldi	North Shore	ancouver cute[3]/ ommunity	rovidence ealth are[4]	ichmond	ncomplete ubtotals
Acute/ Rehabilitation Activity								
IP Cases	2000/01		5,807	12,421	31,240	21,676	10,995	82,139
	Plan		5,691	12,173	27,800-28,000	19,018	10,843	75,525-75,725
IP Days	2000/01		31,413	105,061	308,555	210,106	69,327	724,462
	Plan		25,060-26,400	102,960	272,220-272,920	178,771	65,093	644,104-646,144
IP ALOS	2000/01		5.4	8.5	9.9	9.7	6.3	8.8
	Plan		5.2	8.5	9.7-9.8	9.4	6.0	8.5
ALC Days	2000/01		4,926	16,959	40,974	23,553	16,342	102,754
	Plan		4,827	16,620	28,785	22,375	8,814	81,421
Emergency Visits	2000/01			43,200	51,712	71,624	40,920	207,456
	Plan			43,200	51,712	63,331	40,000	198,243
Continuing Care Residential Activity					Based on avg census	Based on avg census		
Residential Care Beds	2000/01		366	1,318	3,735	836	667	6,922
	Plan		285	951	3,759	687	667	6,349
Continuing Care Community Activity								
Home Support Hour	2000/01*		107,447	313,825	1,278,940		235,500	1,935,712
	Plan		107,447	313,825	1,404,769		240,000	2,066,041
Home Nursing Visits	2000/01*		17,209	30,346	110,640		37,984	196,179
	Plan		17,209	30,346	110,045		38,815	196,415
Home Nursing Cases	2000/01*		723	2,001	4,936			7,660
	Plan		723	2,001	4,750			7,474

* North Shore/Coast Garibaldi baseline is from the latest PURRFECT 1999/2000 figures

K4 Related Developments

Participation in Priority System Performance Improvement Areas

The VCHA is already actively addressing the Priority System Performance Improvement Areas identified in the Ministry's Performance Agreement. We look forward to participating with the Ministry and the other health authorities in the improvement efforts indicated. Our related activities include:

Emergency Health Services

- Vancouver/Richmond review completed
- VCHA program team to be developed and to undertake further coordination activities

Surgical and Procedural Services

- RESIO project involved Vancouver/Richmond hospitals.
- Active participation in Western Canada Wait List project.
- Surgical environmental scan completed.
- VCHA Surgical Council being formed that will lead regional planning.

[3] Vancouver Acute figures are provided by the hospital and are similar but not identical to those in PURRFECT and the Discharge Abstract Database.

[4] Providence Health Care planned figures are estimates provided subsequent to the entity report.

K Implications of the Health System Redesign Plan (continued)

Mental Health Services

- VCHA has been active in interregional planning and will continue implementation of best practices

Home and Community Care

- The North Shore led pilot testing of the MDS tools in BC. Vancouver has been planning implementation for several months. VCHA is proceeding with implementation.
- VCHA has been planning and piloting approaches to shift the mix of services for older adults from an emphasis on residential care towards increased support for independent living in community.

Public and Population Health

- VCHA has been exploring a number of improvements in this area including a falls prevention initiative, tobacco reduction programs and several initiatives in chronic disease management including a self-management program.

Aboriginal Health Plan

The Ministry is familiar with *Healing Ways, the Aboriginal Health and Services Plan* completed in 1999 for Vancouver and Richmond. Implementation of that report has proceeded, including further planning for the creation of a Healing Centre that will require capital and operational funding sources to be identified. A VCHA Aboriginal Health Plan will be developed by the target date of September 2002.

Impact on BC Ambulance Services

The facility changes proposed for Vancouver will reduce the number of active emergency rooms by one, and will reduce the number of acute and residential sites that might send patients to ERs. Hence, this plan simplifies the requirements for the BCAS. The Ambulance Service has been involved in the first stage of Emergency Services planning in the region and will be involved in further system design.

K5 Barriers to Implementation That May Need to Be Addressed on a Provincial Level

The impact of Ministry guidelines regarding severance expenses should be recognized and reconsidered. While plans for cost saving are substantially complete, at the time of submitting these documents it is not yet clear how much of the anticipated severance expense may be booked in 2001/02. This has an effect on the size and timing of the cost reduction strategies due to the Ministry's requirement to balance over the next two years. Furthermore, implementation of a number of strategies has been delayed to enable providence-wide coordination.

While the Performance Agreement documents of February 24th include a provision for capital funding for HA restructuring, it should be noted that the magnitude of the restructuring proposed in this region, particularly including the Providence Legacy Project, will require significant support and enabling assistance from the government.

The service reduction strategy for Vancouver Acute is based on a partial reduction of secondary services for non-residents. This reduction is justified based on regional missions (i.e., it is a better fit with the mission of the other regions), self-sufficiency and utilization equity (i.e., VCHA residents have much less access to secondary services than residents of other regions). This will require us to

K Implications of the Health System Redesign Plan (continued)

encourage non-residents to access secondary care in their home regions. This is more appropriate than for us to institute across-the-board reductions that would compromise access for the people who already have the lowest level of access in the province.

The VCHA encourages the work initiated by the Leadership Council to review provincial policies regarding charges for diagnostic and ambulatory services and residential care fee levels.

K6 Risks

There are risks in any change process. **We believe that over the next three years, as we move forward with our redesign plan, we will be able to implement positive change across our system.** We believe that through careful planning and diligence, risk can be minimized and mitigated. The following is a list of possible impacts associated with the plan. As indicated earlier, the final stage of the budget development process involved reinvestment to minimize these risks. In addition, the final part of this section is a set of risk mitigation strategies that are being put in place to monitor performance and to further avoid or minimize these potential concerns.

a) Expectation to Meet or Exceed Plan

Expectation

- Performance Agreement states that VCHA operating results will be equivalent to or better than those documented in our plan.

Considerations if Service Redesign and Risk Mitigation Strategies are Not Achieved

- Given the change proposed in the plan, and unrest among medical and hospital staff, achievement of targeted performance levels by medical and hospital staff may be delayed.
- Utilization management strategies are key to the plan in that volume projections are a function of a reduction in inappropriate days. A reduction in beds may have impacts on other system components, e.g., ER volumes.
- The Providence Legacy Project is central to Providence Health Care's plan, and its success is subject to a number of factors including agreements with the Ministry of Health Services, timely support with other agreement signatories, external partnerships, and provincial funding.

b) Service Changes in Non-Targeted Areas

Expectation

- Inherent in the plan is protection of tertiary and quaternary services as well as cancer, obstetrical, neonatal services, secondary services for residents of Vancouver and Richmond who already have the lowest level of access in the province, and some secondary services for non-residents.
- The status of the 60 beds closed on a temporary basis during the past fiscal year at the SPH site in response to the nursing shortage will not change. Acute capacity will continue to be impacted.
- The VCHA entities, particularly Providence Health Care and Vancouver Community services have a well-established role in serving the disadvantaged.

K Implications of the Health System Redesign Plan (continued)

Considerations if Service Redesign and Risk Mitigation Strategies are Not Achieved

- Reductions will require careful targeting to secondary non-oncology services for non-residents to guard against a reduction in tertiary or cancer services to Vancouver residents whose level of access is already the lowest in BC.
- Potential compromise to tertiary/quaternary access to care for out of region residents may result in some transfers out of province.
- The significant burden of illness of disadvantaged residents of the region has outstripped provincial funding methodologies. The extent of required service changes could have effects on this population.
- Permanent closure of the SPH beds will impact access to acute care services for some specialized patient populations, as well as efforts to reduce admitting time.

c) Relationships with Medical and Hospital Staff

Expectation

- The plan is a reasoned response to the VCHA budget challenges.

Considerations if Service Redesign and Risk Mitigation Strategies are Not Achieved

- Events in health care, i.e., Bill 29, physician arbitration, and Clinical Academic Service Contracts (CASCs) coupled with the changes required by the plan may provoke upset in medical and hospital staff to the extent of diminished performance, departures, and expertise.
- The plan includes the strategy of creating fully funded CASCs and does not allow for gaps between the funded amount and the cost incurred.

d) ER to Inpatient flow

Expectation

- Schedule A flags Emergency Health Services as a Priority System Performance Improvement area.

Considerations if Service Redesign and Risk Mitigation Strategies are Not Achieved

- Decrease of over $5 million in hospital inpatient services that respond to the ER, the majority of which is designed to be saved through clinical efficiencies.
- The closure of Urgent Care at SVH may impact on emergency services in the VCHA.
- Overall decrease of over 15 medical and psychiatry beds[5].
- Overall result of bed closures is elimination of flexibility in the system to meet the ER demands.
- Increase in off-service medical patients and resultant impact on capacity for planned surgical activity.
- Further constraint and reduction of trauma resources will impact VHHSC mandate as provincial trauma center and increase in trauma diversions within and outside provincial resources.

[5] It is expected that this strategy will be minimized or eliminated through an allocation of about $700,000 from contingency funds.

K Implications of the Health System Redesign Plan (continued)

e) Inpatient to Community Flow/Augmentation in Community Services Capacity (MH and HCC)

Expectation

- Population Needs Based Funding implies VCHA is over-served in residential and community services. No Mental Health allocation also implies over-servicing.
- Schedule A flags (community) Mental Health Services and Home and Community Care as Priority System Improvement areas.
- Schedule A 3) a) i) Increase in early intervention capacity by physician or health service provider for serious mental illness.
- Schedule A 3) a) iii) 3% improvement in 30-day follow-up for mental health discharges.
- Schedule A 4) c) 2% increase in percentage of high-risk clients living at home.

Considerations if Service Redesign and Risk Mitigation Strategies are Not Achieved

- Despite budget adjustments and reinvestments to minimize reductions in community services, the plan contains residential and community reductions.
- VCHA received none of the increase in mental health funding.
- Reduction in rehabilitation days and in DPU and residential beds has potential 'access to care' implications if ALC patient days in acute facilities increase as a consequence.
- Impact on ability to move elderly in the community to residential care beds may impact Emergency Services.

f) Surgical and Procedural Services Access

Expectation

- Schedule A flags appropriate access to Surgical and Procedural Services as a Priority System Performance Improvement area.

Considerations if Service Redesign and Risk Mitigation Strategies are Not Achieved

- Decrease of over $7 million in surgical access, the majority of which is designed to be saved through clinical efficiencies
- V Acute decrease of over 45 surgical beds, most of which can be absorbed onto other units, but which will impact day care and OR capacity.
- The reduction in secondary cases for non-residents strategy could impact wait lists for surgical procedures, and medical professionals.
- Potential increase to unscheduled OR activity given reduction in scheduled work.

g) Academic Mandate

Expectation

- The VCHA is the principal partner for UBC, and as such is the principal base for medical undergraduate, residency and fellowship programs. In addition, the VCHA is the major base for all health sciences education for the province and for externally funded research.

K Implications of the Health System Redesign Plan (continued)

- The expansion of the medical school and of nursing education will present some requirement for additional educational capacity at Vancouver Acute and Providence, but will also require VCHA and its academic partners to examine the potential for broader involvement of Providence Health Care, Richmond, Lions Gate, and other health authorities.

Considerations if Service Redesign and Risk Mitigation Strategies are Not Achieved

- Hampered ability to teach the current number of medical students and residents.
- Increased complexity in planning to expand the medical school as needed.
- May increase risk to Royal College accreditation of some resident and postgraduate training programs and potentially to accreditation of other health sciences programs.
- Attrition of research activity and generation of research funding that supports both research and current clinical programs.

h) Future Impact of the Population Needs Based Funding (PNBF) Model

- If the strategies are implemented as designed, and if the PNBF model continues unchanged, the reduction in secondary services for non-residents will result in a funding reduction in the third year. The magnitude of the adjustment will depend on the overall provincial changes to utilization rates.

i) Relationships with Foundations

Expectation

- The relevant Foundations will support the budget plan.

Considerations if Service Redesign and Risk Mitigation Strategies are Not Achieved

- Assets tied to specific entities may be lost if entities no longer exist or are changed significantly.
- Loss of future capacity to fund raise.

j) Operational Enhancements

Expectation

- The plan assumes there are no requirements to enhance operations or care.

Considerations if Service Redesign and Risk Mitigation Strategies are Not Achieved

- This plan provides no ability for any of the entities to increase investment in areas such as:
  - Those that are currently under funded.
  - Changes in technology.
  - Any specific issues related to access.

K Implications of the Health System Redesign Plan (continued)

k) Relationships with Community

Expectation

- Significant changes must be made to health care to make it patient-centred and financially sustainable.

Considerations if Service Redesign and Risk Mitigation Strategies are Not Achieved

- The community may not support the changes required by this plan.

K7 Risk Mitigation Strategies

- A VCHA (Vancouver, Richmond and North Shore/Coast Garibaldi) utilization management strategy has been developed to mitigate the risk of a negative impact on service volumes projections and increase ER pressures. This strategy includes the following:
  - Ongoing short-term utilization reviews using ISD-A criteria to identify inappropriate days of care with ongoing/rapid feedback and reports to care providers.
  - Regular monitoring of day surgery procedure rates for sentinel procedure groups.
  - Period by period review of length of stay against risk adjusted expected lengths of stay.
  - Trending and ongoing review of 'may not require hospitalization' rates.
  - Ongoing monitoring of 'alternate level of care' days and priority access to long term care facilities.
  - Ongoing implementation of clinical pathways e.g. delirium pathway for high-risk patients identified during pre-admission processes.
  - Review of indications for procedures and clinical outcomes for selected groups.
  - Ongoing review of wait times for selected surgical groupings and diagnostic tests.
- Track adherence to the other intended strategies, for example, tracking secondary cases by place of residence, close monitoring of ER wait times using CAEP standards and baseline indicator information and tracking scheduled/unscheduled OR utilization by Doctor Service.
- Participate with the Ministry and other health authorities in the identified Priority System Performance Improvement Areas:
  - Emergency health service best practice guidelines development.
  - Surgical and procedural services measurement of responsiveness, appropriateness and outcomes.
  - Mental health services use of needs-based and evidence-based best practices.
  - Home and community care improved assessment and increased service capacity.
  - Public/population health development of core programs and best practices.
- Communications – provide clear and consistent information to medical staff, the public and the leadership of other health regions regarding the strategies, their rationale and the impact on service.

(Three phased communications plan now complete; draft with Ministry; see next page for highlights)

- Continue to develop alternate strategies to reduce the requirement for Reductions, for example:
  - Implement other strategies as quickly as possible and defer Reductions as much as budget constraints will permit.
  - Attempt to increase and accelerate shared services/contracting out savings.

K Implications of the Health System Redesign Plan (continued)

- Explore the potential to increase revenue generation, drawing on the ideas submitted from medical and other staff.
- Reassess potential for further administrative and support savings using benchmark data where available.
- Conduct rapid 'best practices' review of the VCHA ORs to identify potential efficiencies.
- Examine VCHA programs, beginning with surgery, to determine opportunities for efficiencies through consolidations.
- PHC plans to complete a core services review of all clinical, administrative and corporate services.

- Assess program priorities by site with particular attention to highly specialized services for residents of BC, secondary services for residents of the Vancouver Coastal region, undergraduate and postgraduate medical education and education of nursing and other health sciences professionals, and research.
- Develop plans for provincial programs such as trauma in concert with PHSA and the other health authorities.
- Create a regional ER program team to optimize and balance secondary emergency services, then review medical and mental health beds to correspond.
- The expansion of the medical school and of nursing education will present some requirement for additional educational capacity at Vancouver Acute and Providence, but will also require VCHA and their academic partners to examine the potential for broader involvement of Providence Health Care, Richmond, Lions Gate and other health authorities.
- Develop structures and mechanisms to increase the involvement of medical staff in organizational leadership.
- Continue to press for Clinical Academic Service Contracts.
- Redevelop mechanisms for communication and consultation with the public.

L Communications Plan

L1 Overview

Goal:

To create a four-month, three-phased plan to communicate the Vancouver Coastal Health Authority's operational planning, fiscal/budget management and health care redesign plan.

Objectives:

- Ensure coordination with other health authorities for initial announcements.
- Provide consistent, timely information relevant to specific audience needs and initiate actions that need to be taken.
- Help engage staff, physicians, and service providers, and encourage cooperation and partnership in meeting budget challenges.
- Ensure managers/others as appropriate take responsibility for two-way communications.
- Position the VCHA as a leader in the renewal of the provincial health delivery system and in restoring public confidence in health care.

Strategies:

- Communicate first with those directly involved in decision-making and those directly affected by potential decisions.
- Inform union's concurrently in cases where union members will potentially be affected.
- Use clear and consistent language to minimize confusion and rumours.
- Use interaction with groups as an opportunity to conduct research to enable further understanding, and assist in long-term trust- and relationship-building efforts.
- Rely as much as possible on existing mechanisms of communication and encourage feedback (and publish feedback to complete the communications loop).
- Emphasize face-to-face communications where ever possible.

L Communications Plan (continued)

L2 Three Phases of Communications Plan

Phase I-March 18-April 19: Setting the Stage

In the next month, we will set the stage for the province-wide announcement by providing information about our challenge and our action. This will demonstrate our commitment to open communication and set the parameters within which changes are proposed. This strategy will allow us to be proactive to the necessity of change, rather than react to the response to it.

Phase II-April 22-May 5: Announcement Period

This phase would include the rollout of the budget messaging and changes that would begin in mid-April. The initial announcements would be coordinated with the other health authorities, followed by VCHA-specific activities. This phase includes a series of information sharing "townhall" meetings with the public.

Phase III-May 6-June 30: Maintenance and Issues Management

This phase consists largely of maintaining the activities outlined in the first and second phases. In this phase, existing communication vehicles will be used to communicate decisions and follow through on the redesign/budget announcement made in mid-April. In this phase we need to try to identify success stories and improvements to share with staff and with external audiences.

L3 Audiences

- ***Internal — Decision Implementing***
  Executive, Operational Planning Team, Directors/Managers, Staff (including unions) and Contracted and funded agencies.
- ***Internal — Decision Shaping***
  Physician leaders, All Physicians, Union leaders, and, Volunteers.
- ***Internal/External — Consumers of Health Services***
  Patients, Clients, and Residents.

External — Decision Shaping

- Media, General Practitioners and other non-staff physicians, Advocacy groups, Other Partners, The public, Donors, Other health authorities, Municipal governments, and First Nations.

External — Decision Making

- Provincial government, and federal government.

L4 Evaluation

While the long-term benefits of the VCHA health system redesign will improve public confidence in the health care system, it remains that actions to be taken in the short term represent significant changes to structures, approaches, and attitudes to which internal and external audiences have become accustomed. Accordingly, we will be evaluating this communications plan on value-based criteria. (We will, of course, continue to monitor coverage and feedback via media, public, staff and other sources as part of our evaluation process.)

Appendix A: Baseline Service Targets

Vancouver Coastal Health Authority Performance Baseline Date: April 12, 2002

00/01

Indicator **Acute**	*Bella Bella*	*Bella Coola*	*Coast Garibaldi*	*North Shore*	*Richmond*	*Vancouver*	*VHHSC*	*Providence*	*VRHB*	*VCHA*	**Provincial Baseline**	
Acute/Rehab Inpatient cases/1,000 pop	304.83	195	109.27	68.38	76.23	71.39			72.4		**93.39**	
Acute/Rehab Inpatient cases by governance	391	364	5,807	12,421	10,955	52,900	31,224	21,676	63,855	82,838	**385,318**	*
Acute/Rehab Inpatient days/1,000 pop	2,141	1,244	683	550	624	662			654	-	**674**	*
Acute/Rehab Inpatient days by governance	1,753	1,465	31,413	105,061	76,220	520,552	310,446	210,106	596,772	736,464	**2,767,225**	*
ALOS by population (not age-standardized)	5.50	5.42	6.09	8.37	7.77	8.95			8.69	8.30	**7.22**	*
ALOS by governance	4.48	4.02	5.41	8.46	6.96	9.84	9.94	9.69	9.35	8.89	**7.18**	*
ALC days/ 1,000 pop	59	41	89	76	128	107			111		**104**	**
ALC days by governance	-	36	4,926	16,959	16,342	64,527	40,974	23,553	80,869	102,790	**422,878**	**
Avg Inpatient RIW by population (not age-std)	1.08	1.19	1.31	1.72	1.63	1.75			1.73	1.67	**1.51**	*
Avg Inpatient RIW by governance	0.81	0.76	1.09	1.67	1.46	2.14	2.20	2.04	2.02	1.89	**1.50**	*
MNRH Days /1,000 pop	78.39	64.37	21.81	13.69	16.73	14.26			14.8		**21.24**	***
MNRH Cases / 1,000 pop	26.25	21.08	7.72	4.22	5.77	4.47			4.76		**6.91**	***
MNRH Days by population	135	201	1,702	2,548	2,660	8,225			10,885	15,471	**86,302**	***
MNRH Cases by population	49	70	609	772	938	2,611			3,549	5,049	**28,090**	***
Average day care RIW/1,000 pop	19.29	13.84	14.64	13.69	12.8	12.02			12.19		**14.21**	**
Average day care RIW by governance	-	0.25	0.19	0.21	0.21	0.25	0.25	0.25	0.25	0.24	**0.21**	**
Daycare Surgeries as % of Surgeries (99/00 only)	0.00%	55.56%	67.40%	57.17%	55.23%	55.37%			55.35%	55.94%	**57.66%**	**
Community (99/00 only)												
Home Support hours/1,000 pop	-	4,091.80	1,508.10	1,547.60	1,694.80	2,162.70			2,073.80		**1,824.50**	
Home Support Cases/1,000 pop	-	19.50	9.10	9.90	11.20	13.70			13.20		**11.20**	
Home Nursing Care visits/1,000 pop	-	11.20	233.80	152.10	181.80	197.30			194.20		**191.20**	
Home Nursing Care cases/1,000 pop	-	0.90	9.70	10.10	9.80	10.20			10.10		**10.30**	
ADC cases per 1,000	-	-	1.90	0.80	1.30	1.80			1.70		**1.40**	
Residential Care days /1,000 pop	3,270.30	1,555.30	1,929.40	2,369.20	1,767.20	2,875.10			2,679.30		**2,276.30**	
Residential Care beds/1,000 pop	8.96	4.26	5.29	6.49	4.84	7.88			7.34		**6.24**	
Residential Care days /1,000 pop over 75	15,797.30	26,500.50	29,551.90	34,930.50	26,891.30	37,951.00			36,065.60		**32,841.80**	
Residential Care beds/1,000 pop over 75	43.28	72.60	80.96	95.70	73.67	103.98			98.81		**89.98**	
% of IC2 or higher home support clients / all IC2 or higher clients in either home support or residential care	0.00%	57.14%	38.03%	38.72%	47.72%	39.80%			40.92%	40.33%	**41.63%**	
Number of IC2 or higher home support clients	-	16	413	1,383	911	4,652			5,563	7,375	**30,559**	
% of residential cases by population that are IC3 or EC	50.00%	100.00%	62.96%	77.96%	79.76%	82.20%			81.91%	79.89%	**77.97%**	

Vancouver Coastal Health Authority Performance Baseline Date: March 23, 2002

00/01

Indicator	*Bella Bella*	*Bella Coola*	*Coast Garibaldi*	*North Shore*	*Richmond*	*Vancouver*	*VHHSC*	*Providence*	*VRHB*	*VCHA*	Provincial Baseline
Emerg											
ER visits											
Admission from Emerg as % of Inpatient Adm (by governance)	21.23%	2.47%	14.10%	4.89%	7.78%	37.02%	54.40%	11.98%	32.00%	26.50%	**24.97%***
Mental Health (included in Acute/Rehab above)											
Mental Health IP days /1,000	288	50	71	47	72	95			90		**77**
Mental Health IP days by governance	396	105	3,874	12,337	12,495	83,598	54,842	28,756	96,093	112,805	**382,660**
Mental Health IP Average RIW by population (not age-standardized)	0.39	0.76	1.42	2.28	2.35	2.26			2.27	2.16	**1.90**
Mental Health IP Average RIW by governance	0.87	0.66	1.19	2.31	2.38	2.29	2.40	2.11	2.30	2.20	**1.89**
Mental Health ALC days as % of Total Mental Health Days by population (not age-std)	0.00%	0.00%	12.94%	22.34%	21.48%	18.01%			18.63%	18.56%	**17.24%**
Mental Health ALC days as % of Total Mental Health Days by governance	0.00%	0.00%	17.19%	24.60%	23.25%	16.31%	16.44%	16.07%	17.21%	17.95%	**17.19%**
Rehab (included in Acute/Rehab above)											
Cases/1,000 pop	1.97	1.37	0.55	0.19	0.64	0.87			0.82		**0.35**
Cases by governance	-	-	-	-	-	1,181	646	535	1,181	1181	**1,449**
Days/1,000 pop	94	71	20	8	30	41			38		**15**
Days by governance	-	-	-	-	-	53,823	30,480	23,343	53,823	53,823	**60,158**
ALOS by population (not age-standardized)	46.00	49.25	36.55	43.14	47.39	47.87			47.79	46.80	**42.86**
ALOS by governance	-	-	-	-	-	45.57	47.18	43.63	45.57	45.57	**41.52**

Notes:

By population refers to the patient's region of residence. This is a crude figure, not an age standardized figure

By governance refers to the hospital's region

/1,000 pop refers to the age standardized rate based on the patient's region of residence and the population of the region in question

*Acute, Rehab, DPU, ALC, mental health and no newborns

**No Newborns

***No Therapeutic abortions, no newborns

Appendix B: 2002/03 to 2004/05 Budget Management Plan

Vancouver Coastal Health Authority

2002/03 to 2004/05 Budget Management Plan ($ - millions)

	VCHA Total	
2001/02 Projected Expenditures	1,901,196.00	
2001/02 Projected "Structural" Surplus / (Deficit) Before Restructuring & 1-TimeCosts	(42,255.00)	
Unfunded Collective Agreements	(5,887.00)	
CASC Unfunded	(6,600.00)	(**Assumes 6.0 Million in funding)
2001/02 Revised Projection	(54,742.00)	

	Total	2002/03		2003/04		2004/05	
		$	FTE's	$	FTE's	$	FTE's
Projected Surplus / (Deficit) Prior to Management Reduction Strategies	(54,742.00)	(54,742.00)		(18,972.75)		18,972.75	
Capital Payback		-		(22,100.00)		(2,520.00)	
Severance Reversal		-		15,410.00			
Running Rate Position		(54,742.00)	-	(25,662.75)	-	16,452.75	-
CASC Expense	(44,045.00)	(44,045.00)		-		-	
CASC Revenue	44,045.00	44,045.00		-		-	
Cost Pressures Total	(173,983.00)	(121,608.00)	-	(43,913.00)	-	(8,462.00)	-
Ambulance Services (Contingency)	(2,000.00)	(2,000.00)					
Capital Advances	12,620.00	22,100.00		2,520.00		(12,000.00)	
Severance Cost	(15,410.00)	(15,410.00)					
MOH Funding	85,700.00	85,700.00	-	-	-	-	-
Management Reduction Strategies:							
Revenue Generation							
1. Additional funding from MoHS							
2. Acute Treatment Initiatives	6,468.13	5,510.38		957.75			
3. Community Care Initiatives	414.00	414.00		-			
Subtotal Revenue Generation	6,882.13	5,924.38		957.75			

Appendix B: 2002/03 to 2004/05 Budget Management Plan (continued)

General Efficiencies (non-clinical)							
1. Support and Admin	25,905.88	16,485.39	170.92	8,671.24	97.74	749.25	10.00
2. Shared Services	40,000.00	3,000.00	60.00	29,483.48	475.00	7,516.52	121.10
3. Corporate Services (Van/Rich)	4,538.41	3,784.33	33.22	754.08	8.08		
4. Information Services	2,624.16	2,044.21	12.94	579.95	8.04		
Subtotal General Efficiencies (non-clinical)	73,068.45	25,313.93	277.08	39,488.75	588.86	8,265.77	131.10
Best Practices (clinical)							
1. Acute Services	30,800.97	11,497.38	149.34	18,103.59	238.66	1,200.00	10.30
2. Community Care Initiatives							
--Continuing Care Community	4,665.39	2,565.01	74.67	2,100.38	27.64	-	-
--Continuing Care Residential	10,607.06	6,209.06	70.62	4,247.25	50.52	150.75	2.00
-- Mental Health	4,863.62	3,650.25	46.24	1,213.37	17.63	-	-
-- Public/Preventative Health	1,799.04	1,157.74	7.20	641.30	3.18	-	-
3. Redesign initiatives							-
4. Role Conversion	4,731.00			4,731.00	73.92	-	-
Subtotal Best Practices (clinical)	57,467.08	25,079.44	348.07	31,036.89	411.55	1,350.75	12.30
Program Reductions							
1. Role Conversion							
2. Reductions:							
--Acute Services	11,339.00	4,447.40	61.43	6,891.60	98.33		
--Continuing Care Community	2,390.89	894.63	10.31	1,496.26	17.52		
--Continuing Care Residential	5,614.46	1,642.00	33.50	3,972.46	89.28		
-- Mental Health	2,293.51	1,597.05	20.21	696.46	9.24		
-- Public/Preventative Health	3,576.75	2,088.42	23.46	1,488.33	20.69		
3. Bed Consolidations							
Subtotal Program Reductions	25,214.61	10,669.50	148.91	14,545.11	235.06	-	-
Total Management Reduction Strategies	162,632.27	66,987.25	774.06	86,028.50	1,235.47	9,616.52	143.40
Strategies as a % of 2001/02 Expenditures (a)	8.6%						
Revised Projection	14,817.27	(18,972.75)	774.06	18,972.75	1,235.47	5,607.27	143.40

(a) Based on old V/RHB funding allocations